EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0006	The provider was not enrolled as an eligible provider on the date(s) of service. The provider should verify the date of service and the date the provider became an enrolled provider (using the Provider Turn-Around form). The claim should be rebilled if the date of provider enrollment is prior to, or on, the date of service.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Changed as of 10/98	N95	This provider type/provider specialty may not bill this service. Note: New code 7/31/01, Modified 2-28-03
0007	The provider has not submitted a complete cost report or has failed to provide other documentation requested by the Department of Community Health.	OA	Other Adjustments	17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N29	Missing documentation/orders/notes/ summary/report/chart.. Note: Modified 8-1-05
0008	HBP invoice adjustment.	CO	Contractual Obligations	95	Benefits adjusted. Plan procedures not followed. Note: Changed as of 6/00	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
0011	Incomplete/invalid taxpayer identification number (TIN) submitted by you. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of TIN. You may rebill this claim after you have notified the Department of Community Health of your correct TIN.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.
0013	The claim was submitted electronically and there is no authorization for this billing agent from the provider on file with Provider Enrollment. The provider must submit a completed DCH-1343, Billing Agent Authorization Form, to Provider Enrollment, wait for verification of receipt of the DCH-1343 (on the Provider Turn-Around form), and then rebill the claim.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate Note: Changed as of 2/02	N51	Electronic interchange agreement not on file for provider/submitter.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0014	The date of service is more than 180 days from the Julian Date of the Prior Authorization Number.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0015	The date of service is more than 180 days from the Julian Date of the Prior Authorization Number.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0019	The beneficiary ID Number is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	31	Claim denied as patient cannot be identified as our insured.	MA61	Missing/incomplete/invalid social security number or health insurance claim number. Note: Modified 2-28-03
0020	The beneficiary ID Number is not numeric. The provider should verify the beneficiary ID Number. The claim should be corrected and rebilled.	CO	Contractual Obligations	31	Claim denied as patient cannot be identified as our insured.	MA61	Missing/incomplete/invalid social security number or health insurance claim number. Note: Modified 2-28-03
0021	The beneficiary ID Number is invalid. The provider should verify the beneficiary ID Number. The claim should be corrected and rebilled.	CO	Contractual Obligations	31	Claim denied as patient cannot be identified as our insured.	MA61	Missing/incomplete/invalid social security number or health insurance claim number. Note: Modified 2-28-03
0022	The beneficiary ID Number does not match any beneficiary ID Number on the Eligibility Verification System.	CO	Contractual Obligations	31	Claim denied as patient cannot be identified as our insured.	MA62	Missing/incomplete/invalid social security number or health insurance claim number. Note: Modified 2-28-03
0023	The beneficiary was not eligible for Medicaid or Adult Benefits Waiver Program coverage on the date(s) of service.	CO	Contractual Obligations	31	Claim denied as patient cannot be identified as our insured.	N30	Patient ineligible for this service. Note: Modified 6-30-03
0024	The beneficiary was not eligible for Children's Special Health Care Services Program coverage on the date(s) of service. The provider should verify the beneficiary ID Number with the Eligibility Notice. If the date of service is within the period of beneficiary eligibility, the claim should be rebilled.	CO	Contractual Obligations	31	Claim denied as patient cannot be identified as our insured.	N30	Patient ineligible for this service. Note: Modified 6-30-03
0025	The beneficiary is enrolled in a Medicaid Health Plan. The provider should contact the Medicaid Health Plan for reimbursement.	CO	Contractual Obligations	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. Note: Changed as of 6/00	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0026	The beneficiary is eligible for Children's Special Health Care Services Program coverage on the date of service. The explanation code is for informational purposes only.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0027	The beneficiary is eligible for both Children's Special Health Care Services and Medicaid coverage on the date(s) of service. The explanation code is for informational purposes only.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0028	Claim pended for manual correction	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N45	Payment based on authorized amount.
0029	The beneficiary is eligible for Adult Benefits Waiver Program coverage on the date(s) of service. The explanation code is for informational purposes only.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0036	The beneficiary is eligible for only Maternity Outpatient Medical Services Program coverage on the date of service. The explanation code is for informational purposes only.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 8-22-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0037	Reimbursement for a Resident County Hospitalization claim(s) must be obtained from the beneficiary's **Department of Human Services,** not Medicaid. The provider should contact the local Family Independence Agency office.	CO	Contractual Obligations	31	Claim denied as patient cannot be identified as our insured.	N193	Specific federal/state/local program may cover this service through another payer. Note: (New Code 2-28-03)
0038	The **Department of Human Services** has not entered the proper authorization on the Eligibility Verification System.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0040	The principal diagnosis code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	**D21**	**This (these) diagnosis(es) is (are) missing or are invalid. Change 4/06.**	MA63	Missing/incomplete/invalid principal diagnosis. Note: Modified 2-28-03
0041	The principal diagnosis code does not match the diagnosis file.	CO	Contractual Obligations	**167**	**This (these) diagnosis (es) is (are) not covered. Change 4/06.**	MA63	Missing/incomplete/invalid principal diagnosis. Note: Modified 2-28-03

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0042	The principal diagnosis code is under review for Program criteria.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	MA63	Missing/incomplete/invalid principal diagnosis. Note: Modified 2-28-03
0044	The other diagnosis code is under review for Program criteria.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	M76	Missing/incomplete/invalid diagnosis or condition. Note: Modified 2-28-03
0045	The principal diagnosis code is being manually reviewed as the beneficiary's age does not fall within the normally accepted age range for this diagnosis.	CO	Contractual Obligations	9	The diagnosis is inconsistent with the patient's age.	MA63	Missing/incomplete/invalid principal diagnosis. Note: Modified 2-28-03
0046	The principal diagnosis code is being manually reviewed as the diagnosis is not normally acceptable for the beneficiary's sex.	CO	Contractual Obligations	10	The diagnosis is inconsistent with the patient's gender. Note: Changed as of 2/00	MA63	Missing/incomplete/invalid principal diagnosis. Note: Modified 2-28-03
0049	The principal diagnosis code is being manually reviewed.	CO	Contractual Obligations	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid. Note: Changed as of 6/00	MA63	Missing/incomplete/invalid principal diagnosis. Note: Modified 2-28-03
0050	The principal diagnosis code is being manually reviewed as this type of provider does not normally render treatment for this diagnosis.	CO	Contractual Obligations	12	The diagnosis is inconsistent with the provider type.	MA63	Missing/incomplete/invalid principal diagnosis. Note: Modified 2-28-03
0051	The procedure code billed does not reflect the appropriate treatment for the principal diagnosis.	CO	Contractual Obligations	11	The diagnosis is inconsistent with the procedure.	M51	Missing/incomplete/ invalid procedure code(s). Note: Modified 12-2-04 Related to N301
0058	The procedure code billed does not reflect the appropriate treatment for the secondary diagnosis.	CO	Contractual Obligations	11	The diagnosis is inconsistent with the procedure.	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301
0059	The other diagnosis code is being manually reviewed as this type of provider does not normally render treatment for this diagnosis.	CO	Contractual Obligations	12	The diagnosis is inconsistent with the provider type.	MA63	Missing/incomplete/invalid principal diagnosis. Note: Modified 2-28-03
0061	The other diagnosis code does not match the diagnosis file.	CO	Contractual Obligations	**167**	**This (these) diagnosis (es) is (are) not covered. Change 4/06.**	M76	Missing/incomplete/invalid diagnosis or condition. Note: Modified 2-28-03
0062	The other diagnosis code is being manually reviewed as this type of provider does not normally render treatment for this diagnosis.	CO	Contractual Obligations	12	The diagnosis is inconsistent with the provider type.	M76	Missing/incomplete/invalid diagnosis or condition. Note: Modified 2-28-03
0063	The other diagnosis code is being manually reviewed as the diagnosis is not normally acceptable for the beneficiary's sex.	CO	Contractual Obligations	10	The diagnosis is inconsistent with the patient's gender. Note: Changed as of 2/00	M76	Missing/incomplete/invalid diagnosis or condition. Note: Modified 2-28-03

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0064	The other diagnosis code is being manually reviewed as the beneficiary's age does not fall within the normally accepted age range for this diagnosis.	CO	Contractual Obligations	9	The diagnosis is inconsistent with the patient's age.	M76	Missing/incomplete/invalid diagnosis or condition. Note: Modified 2-28-03
0065	The claim has a prior authorization number which is not yet on file with the Department of Community Health for this beneficiary, OR services on the prior authorization form have been deleted or already paid.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0066	The claim has a prior authorization number which is not yet on file with the Department of Community Health for this beneficiary, OR services on the prior authorization form have been deleted or already paid.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0067	The claim has a prior authorization number which is not yet on file with the Department of Community Health for this beneficiary, OR services on the prior authorization form have been deleted or already paid.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0068	The claim is being reviewed for a prior authorization condition.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0072	Dental copay deduction.	CO	Contractual Obligations	3	Co-payment Amount	N45	Payment based on authorized amount.
0073	The tooth number/letter is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N37	Missing/incomplete/invalid tooth number/letter. Note: Modified 2-28-03
0074	The tooth surface is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N75	Missing/incomplete/invalid tooth surface information. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0075	The tooth number/letter is required. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N37	Missing/incomplete/invalid tooth number/letter. Note: Modified 2-28-03
0076	The tooth surface is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N75	Missing/incomplete/invalid tooth surface information. Note: Modified 2-28-03
0078	The quantity on the claim exceeds the allowable quantity for this procedure code. The explanation code is for informational purposes only.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many services. Note: New as of 10-02	M53	Missing/incomplete/invalid days or units of service. Note: Modified 2-28-03
0079	The injury code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M44	Missing/incomplete/invalid condition code. Note: Modified 2-28-03
0080	The injury code is invalid. The injury code should be corrected and the claim should be rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M44	Missing/incomplete/invalid condition code. Note: Modified 2-28-03
0087	This procedure code is being manually reviewed to determine the medical necessity and/or appropriateness of the service. The provider is required to forward the medical record for this date of service and any other documentation which supports this service to: Selective Edit Unit, Department of Community Health, P.O. Box 30479, Lansing, MI 48909. If records are not received within 30 days of the payment date of this Remittance Advice on which this explanation code first appears for this claim, the claim will be rejected.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	M127	Missing patient medical record for this service. Note: Modified 2-28-03 Related to N237
0088	**The Medicaid copayment has been deducted.** (Changed 5-01-06) The explanation code is for informational purposes only.	PR	Patient's Responsibility; Revised 6-06	3	Co-payment Amount	N45	Payment based on authorized amount.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0089	The required procedure or revenue code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	**181**	**Payment adjusted because this procedure code was invalid on the date of service. Change 4/06.**	M50	Missing/incomplete/invalid revenue code(s). Note: Modified 2-28-03
0090	The type of service code is missing or invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	**181**	**Payment adjusted because this procedure code was invalid on the date of service. Change 4/06.**	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301
0091	Incomplete or invalid procedure code. The claim should be corrected and rebilled.	CO	Contractual Obligations	**181**	**Payment adjusted because this procedure code was invalid on the date of service. Change 4/06.**	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301
0092	The procedure code is invalid, OR the combination of the type of service code and procedure code is invalid, OR the procedure code is incorrect for the provider OR for Outpatient Hospital, the required HCPCS code is missing. The provider should verify the procedure code, type of service code, and provider type code. The claim should be corrected and rebilled. OR The Hospice provider is billing for room and board, and the nursing facility provider ID Number is not correct or is missing. A new or corrected enrollment form with the correct nursing facility ID Number should be submitted to MDCH. The claim should be rebilled once MDCH has entered the correct information on its payment system.	CO	Contractual Obligations	**181**	**Payment adjusted because this procedure code was invalid on the date of service. Change 4/06.**	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301
0093	The procedure code or the combination of the type of service code and procedure code is not covered on the date of service. The provider should verify the procedure code, type of service code, and date of service. Provider should also verify the billing procedure with current manual material for possible changes. The claim should be corrected and rebilled.	CO	Contractual Obligations	**181**	**Payment adjusted because this procedure code was invalid on the date of service. Change 4/06.**	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301
0094	Claim pended for manual correction.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N301	Missing/incomplete/invalid procedure dates(s). Note: New code 12-2-04

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0095	The place of service is not acceptable for this procedure code or type of service.	CO	Contractual Obligations	5	The procedure code/bill type is inconsistent with the place of service.	M77	Missing/incomplete/invalid place of service. Note: Modified 2-28-03
0096	The procedure code is being manually reviewed as the beneficiary's age does not fall within the normally accepted age range for the procedure.	CO	Contractual Obligations	6	The procedure/revenue code is inconsistent with the patient's age. Note: Changed as of 6/02	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301
0097	The procedure code is being manually reviewed as the procedure is not normally acceptable for the beneficiary's sex.	CO	Contractual Obligations	7	The procedure/revenue code is inconsistent with the patient's gender. Note: Changed as of 6/02	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301
0099	The procedure code is being manually reviewed as this type of provider does not normally render the indicated procedure.	CO	Contractual Obligations	**170**	**Payment is denied when performed/billed by this type of provider. Change 4/06.**	N95	This provider type/provider specialty may not bill this service. Note: New code 7-31-01, Modified 2-28-03
0100	The amount to be paid for this procedure is being determined manually.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N45	Payment based on authorized amount.
0101	Reimbursement for the procedure billed has been made based on Medicaid's allowable quantity. The quantity has been reduced to Medicaid's allowable quantity. The Remittance Advice indicates the quantity on which reimbursement is based. The explanation code is for informational purposes only.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many services. Note: New as of 10-02	M53	Missing/incomplete/invalid days or units of service. Note: Modified 2-28-03
0102	The amount billed is being manually reviewed.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0103	The amount to be paid on this claim is different than the total Medicare coinsurance and/or deductible amounts.	CO	Contractual Obligations	2	Coinsurance Amount	M54	Missing/incomplete/invalid days or units of service. Note: Modified 2-28-03
0104	This procedure code or drug code is being manually reviewed for Program criteria.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N35	Program integrity/utilization review decision.
0105	This service may have a comprehensive/component or a mutually exclusive relationship with another service billed for the same date.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0107	The sum of Medicare and other insurance payments equals or exceeds Medicaid's rate. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed as of 2/01; update 4/06.**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0108	Claim pended for manual correction.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error's). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N45	Payment based on authorized amount.
0109	Claim pended for manual correction.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error's). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N45	Payment based on authorized amount.
0110	The Level of Care shown on the claim does not match the Level of Care on Eligibility Verification System for this beneficiary.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M47	Missing/incomplete/invalid internal or document control number. Note: Modified 2-28-03
0116	Medicare coverage may be available when a diagnosis or procedure is for chronic renal disease.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2-01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0117	Claim pended for manual correction.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N255	Missing/incomplete/invalid billing provider taxonomy. Note: New code 12-2-04
0118	Reimbursement number is invalid.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New code 12-2-04
0119	The provider does not have the appropriate specialty on file with Provider Enrollment to be reimbursed for this service. This service must not be rebilled.	CO	Contractual Obligations	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Changed as of 6/02	N95	This provider type/provider specialty may not bill this service. Note: New code 7-31-01, Modified 2-28-03
0120	The primary surgical procedure code is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	**181**	**Payment adjusted because this procedure code was invalid on the date of service. Change 4/06.**	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301
0121	The primary surgical procedure code does not match the procedure file. The claim should be corrected and rebilled.	CO	Contractual Obligations	**181**	**Payment adjusted because this procedure code was invalid on the date of service. Change 4/06.**	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0122	Operating room charges were billed without a primary surgical procedure code. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301
0125	The secondary surgical procedure code is invalid. The secondary surgical procedure code should be corrected and the claim should be rebilled.	CO	Contractual Obligations	**181**	**Payment adjusted because this procedure code was invalid on the date of service. Change 4/06.**	M67	Missing/incomplete/invalid other procedure code(s). Modified 12-2-04 Related to N302
0126	The secondary surgical procedure code does not match the procedure file. The provider should correct the secondary surgical procedure code and rebill the claim.	CO	Contractual Obligations	**181**	**Payment adjusted because this procedure code was invalid on the date of service. Change 4/06.**	M67	Missing/incomplete/invalid other procedure code(s). Modified 12-2-04 Related to N302
0127	The surgical procedure is being reviewed because of an emergent or urgent condition.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0130	The individual consideration code is invalid. The explanation code is for informational purposes only.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	M78	Missing/incomplete/invalid HCPCS modifier. Note: Modified 2-28-03
0132	The disposition of this claim/service is pending further review.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N45	Payment based on authorized amount.
0136	The attending physician provider ID Number is missing. The provider should enter the correct attending physician provider ID Number and rebill.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N253	Missing/incomplete/invalid attending provider primary identifier. Note: New Code 12-2-04
0137	The attending physician provider ID Number is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N253	Missing/incomplete/invalid attending provider primary identifier. Note: New Code 12-2-04

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0140	The beneficiary was eligible for the Adult Benefits Waiver Program coverage on the date of service but no authorization from the local Family Independence Agency office is on file for the service. If the provider did receive authorization from the local Family Independence Agency office, the claim may be rebilled with a copy of the authorization attached.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	MA43	Missing/incomplete/invalid patient status. Note: Modified 2-28-03
0141	This type of provider is not authorized to provide treatment under the Adult Benefits Waiver Program.	CO	Contractual Obligations	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Changed as of 6/02	N95	This provider type/provider specialty may not bill this service. Note: New code 7-31-01, Modified 2-28-03
0142	The place of service is not acceptable for the Adult Benefits Waiver Program. The service must not be rebilled.	CO	Contractual Obligations	5	The procedure code/bill type is inconsistent with the place of service.	M77	Missing/incomplete/invalid place of service. Note: Modified 2-28-03
0143	The procedure or drug code is not covered for the Adult Benefits Waiver Program.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03
0147	The Maternity Outpatient Medical Services program is limited to services related to pregnancy. This service is from a non-covered provider type or is not related to the patient's pregnancy.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03
0148	The Maternity Outpatient Medical Services program is limited to outpatient services and delivery-related services. This place of service is not covered.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03
0150	Did not complete or enter accurately the ordering/referring provider ID Number. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N265	Missing/incomplete/invalid ordering provider primary identifier. Note: New code 12-2-04
0151	Did not complete or enter accurately the ordering/referring provider ID Number. The claim should be corrected and rebilled.	CO	Contractual Obligations	**183**	**The referring provider is not eligible on the date of service. Change 4/06.**	N265	Missing/incomplete/invalid ordering provider primary identifier. Note: New code 12-2-04
0152	The ordering/referring physician ID Number is being reviewed. The explanation code is for informational purposes only.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N265	Missing/incomplete/invalid ordering provider primary identifier. Note: New code 12-2-04

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0153	The pharmacy copayment has been deducted. The explanation code is for informational purposes only.	CO	Contractual Obligations	3	Co-payment Amount	N45	Payment based on authorized amount.
0154	The date of service is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: Modified 2-28-03
0155	The date of service is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: Modified 2-28-03
0156	The date of service is after the date the claim was received by the Department of Community Health. The date should be verified. If appropriate, the claim should be corrected and rebilled. If the date is correct, the service must not be rebilled.	CO	Contractual Obligations	110	Billing date predates service date.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: Modified 2-28-03
0157	The claim line date of service is not included in the range of dates indicated by the begin to end dates of service. If appropriate, the claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: Modified 2-28-03
0158	The claim was received by the Department of Community Health more than one year after the date of service.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0161	The provider is a hospital-based physician. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charges exceed your contracted/legislated fee arrangement.	N45	Payment based on authorized amount.
0162	The provider does not have the appropriate specialty on file with Provider Enrollment to be reimbursed for this procedure. The provider must submit a copy of his/her board certification or proof of completing a residency in the specialty area, along with his/her provider ID Number, to the Provider Enrollment Unit.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Changed as of 10/98	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New Code 12-2-04
163	Inpatient Friday/Saturday elective admission.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0164	The admission date is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA40	Missing/incomplete/invalid admission date. Note: Modified 2-28-03
0165	The admission date is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA40	Missing/incomplete/invalid admission date. Note: Modified 2-28-03
0166	The admission date is after the begin date of service. The date(s) should be verified. If appropriate, the claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA40	Missing/incomplete/invalid admission date. Note: Modified 2-28-03
0167	The Resident County Hospitalization Program does not cover this dental procedure.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03
0168	The provider's total charge exceeds Medicaid's rate; the Medicaid payment has been reduced due to Medicare and other insurance payments. This results in a Medicaid payment, but the amount is less than requested. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0169	The provider type on the prior authorization form on file with the Department of Community Health does not match the provider type on the claim.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N54	Claim information is inconsistent with pre-certified/authorized services.
0170	The sum of Medicaid and other insurance payments equals or exceeds Medicaid's rate.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0171	The procedure code on the claim does not match the procedure code on the prior authorization form on file with the Department of Community Health.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N54	Claim information is inconsistent with pre-certified/authorized services.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0173	The Dental Invoice tooth number/letter does not match the tooth number/letter on the prior authorization form on file with the Department of Community Health. The provider should verify the tooth number/letter billed with the number/letter that was prior authorized. If they match, the provider should contact the dental consultant.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N37	Missing/incomplete/invalid tooth number/letter. Note: Modified 2-28-03
0174	The begin date of service is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M52	Missing/incomplete/invalid "from" date(s) of service. Note: Modified 2-28-03
0175	The begin date of service is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M52	Missing/incomplete/invalid "from" date(s) of service. Note: Modified 2-28-03
0176	The begin date of service is after the end date of service. The date(s) should be verified. If appropriate, the claim should be corrected and rebilled. If the date is correct, the service must not be rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed: Note: Modified 2-28-03
0177	The tooth surface on the Dental Invoice does not match the tooth surface on the prior authorization form on file with the Department of Community Health. The provider should verify the tooth surface billed with the surface that was prior authorized. If they match, the provider should contact the dental consultant.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N75	Missing/incomplete/invalid tooth surface information. Note: Modified 2-28-03
0178	The quantity indicated on the claim is greater than the quantity indicated on the prior authorization form on file with the Department of Community Health.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M53	Missing/incomplete/invalid days or units of service. Note: Modified 2-28-03
0180	The procedure code billed has been deleted from the prior authorization form on file with the Department of Community Health.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0181	The prior authorization on file with the Department of Community Health indicates the procedure code has previously been paid. The service must not be rebilled.	CO	Contractual Obligations	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: Modified 6-30-03
0183	The date of service is prior to the date of the prior authorization.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: Modified 2-28-03
0184	The end date of service is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M59	Missing/incomplete/invalid “to” date(s) of service. Note: Modified 2-28-03
0185	The end date of service is invalid OR, for Outpatient Hospital, the claim line date of service is not included in the range of dates indicated by the from and through dates on the claim.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M59	Missing/incomplete/invalid “to” date(s) of service. Note: Modified 2-28-03
0186	The end date of service is after the date the claim was received by the Department of Community Health. The date(s) should be verified. If appropriate, the claim should be corrected and rebilled.	CO	Contractual Obligations	110	Billing date predates service date.	M59	Missing/incomplete/invalid “to” date(s) of service. Note: Modified 2-28-03
0187	The range from begin to end date of service covers more than one month. The provider should rebill each month on a separate claim.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
0188	There is no authorization for long-term care on Eligibility Verification System for at least one of the dates covered by this claim.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0190	Invalid prior authorization number. The claim should be corrected and rebilled.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0191	The prior authorization number does not digit-check.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0192	The provider does not have the appropriate specialty on file to be reimbursed for this procedure. If the provider has the appropriate specialty, then the Provider Enrollment Unit should be notified and the claim rebilled. If the provider does not have the appropriate specialty, then the service must not be rebilled.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Changed as of 10/98	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New code 12-2-04
0193	The Children's Special Health Care Services Program has not authorized this date of service.	CO	Contractual Obligations	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded. Note: Changed as of 2/01	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0194	The Children's Special Health Care Services Program has not authorized this provider type to render treatment to this child.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Changed as of 10/98	N95	This provider type/provider specialty may not bill this service. Note: New code 7-31-01, Modified 2-28-03
0195	The Children's Special Health Care Services Program has not authorized this provider ID Number to render treatment to this child.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Changed as of 10/98	N95	This provider type/provider specialty may not bill this service. Note: New code 7-31-01, Modified 2-28-03
0196	This service is not covered for adults age 21 and over effective for dates of service 10-1-03 and after.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03
0197	The service requires prior authorization and the prior authorization number is not on the claim.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0199	The procedure was reimbursed at the lesser of charge or screen and adjusted for modifiers and policies. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Chagned 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0201	The provider ID Number on the claim does not match the provider ID Number that was authorized to treat this beneficiary. The provider should check the ID Number and rebill using the correct provider ID number.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New Code 12-2-04
0202	Medicaid has been billed before six months have elapsed since billing the other insurance carrier. The provider should wait until six months after billing the other insurance carrier before rebilling the claim.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0203	The provider must bill the other insurance carrier first for ancillary services. (The Eligibility Verification System indicates that the beneficiary has other insurance, but the claim indicates no action was taken by the other insurance carrier.) The provider should bill the other insurance carrier, await a response, then rebill the claim.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0204	Client has commercial insurance coverage in addition to Medicare A and B.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0205	Provider must bill other insurance carrier first for daily care.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0206	Invoice Other Insurance Code requires further documentation for daily care services.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N29	Missing documentation/orders/notes/ summary/report/chart.. Note: Modified 8-1-05
0209	The vision copayment has been deducted. The explanation code is for informational purposes only.	CO	Contractual Obligations	3	Co-payment Amount	N45	Payment based on authorized amount.
0210	The required replacement claim or adjustment has an invalid original claim reference number.	CR	Correction and Reversals	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim. Note: Changed as of 6/03	N29	Missing documentation/orders/notes/ summary/report/chart.. Note: Modified 8-1-05

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0211	The required original claim reference number is missing from the replacement claim or adjustment. The claim should be corrected and rebilled.	CR	Correction and Reversals	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim. Note: Changed as of 6/03	N29	Missing documentation/orders/notes/ summary/report/chart.. Note: Modified 8-1-05
0212	Claim pended for manual review.	CR	Correction and Reversals	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N225	Incomplete/invalid documentation/ orders/notes/summary/report/chart. Note: Modified 8-1-05
0215	The adjustment invoice amount billed is not equal to zero.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA67	Correction to a prior claim.
0216	The Medicaid Health Plan has billed too far in advance. The date(s) should be verified. If incorrect, the claim should be corrected and rebilled.	CO	Contractual Obligations	110	Billing date predates service date.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: Modified 2-28-03
0217	The end date of service does not equal the last day of the month.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M59	Missing/incomplete/invalid “to” date(s) of service. Note: Modified 2-28-03
0218	The begin date of service does not equal the first day of the month.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M52	Missing/incomplete/invalid “from” date(s) of service. Note: Modified 2-28-03
0219	The primary surgical procedure date is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA66	Missing/incomplete/invalid principal procedure code. Note: Modified 12-2-04 Related to N303

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0220	The primary surgical procedure date is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA66	Missing/incomplete/invalid principal procedure code. Note: Modified 12-2-04 Related to N303
0222	The prescription number is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Note: Modified 2-28-03
0223	The prescription number is invalid.	CO	Contractual Obligations	17	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N225	Incomplete/invalid documentation/ orders/notes/summary/report/chart. Note: Modified 8-1-05
0224	The beneficiary is restricted to primary providers as indicated on the beneficiary's ID Card.	CO	Contractual Obligations	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Changed as of 6/02	N95	This provider type/provider specialty may not bill this service. Note: New code 7-31-01, Modified 2-28-03
0225	The beneficiary requires prior authorization as indicated on the beneficiary's ID Card.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Modified 2-28-03
0228	The pharmacy's prescribing/referring physician is not the restricted beneficiary's primary provider as indicated on the beneficiary's ID Card.	CO	Contractual Obligations	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Changed as of 6/02	N95	This provider type/provider specialty may not bill this service. Note: New code 7-31-01, Modified 2-28-03
0229	The required emergent condition code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care.	M44	Missing/incomplete/invalid condition code. Note: Modified 2-28-03
0230	The emergent condition code is invalid.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care.	M44	Missing/incomplete/invalid condition code. Note: Modified 2-28-03
0231	Begin date of service prior to implementation of Medicaid Health Plan.	CO	Contractual Obligations	26	Expenses incurred prior to coverage.	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.
0232	Beneficiary is CSHCS or CSHCS/Medicaid Eligible on date of service.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0233	The referral code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA42	Missing/incomplete/invalid admission source. Modified 2-28-03

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0234	The referral code is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA42	Missing/incomplete/invalid admission source. Modified 2-28-03
0235	The provider ID Number and the procedure code billed are not compatible.	CO	Contractual Obligations	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Changed as of 6/02	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301
0236	The beneficiary was not enrolled in a Medicaid Health Plan on the date(s) of service.	CO	Contractual Obligations	**177**	**Payment denied because the patient has not met the required eligibility requirements. Change 4/06.**	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.
0238	The locator code is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0241	The claim line was billed with modifiers indicating the service is not covered by Medicare.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M78	Missing/incomplete/invalid HCPCS modifier. Note: Modified 2-28-03
0243	The coordination of benefits indicator or the Medicare status code is invalid as it does not match the payment, deductible or coinsurance information entered on the claim.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N245	Incomplete/invalid plan information for other insurance. Note: New code 8-1-04
0244	The claim is being reviewed for possible Medicare coverage.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2-01	N245	Incomplete/invalid plan information for other insurance. Note: New code 8-1-04
0245	The claim is being reviewed for possible Medicare coverage.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2-01	N245	Incomplete/invalid plan information for other insurance. Note: New code 8-1-04
0246	The beneficiary is eligible for Medicare, however, the claim shows the beneficiary is under age 65.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2-01	MA92	Missing plan information for other insurance Note: Modified 2-1-04 Related to N245

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0247	The beneficiary is age 65 or older and there is no indication that Medicare has made payment or applied the charge to the beneficiary's deductible.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2-01	MA92	Missing plan information for other insurance Note: Modified 2-1-04 Related to N245
0251	The facility is billing for ancillary services that have not been approved by Medicare. Only those ancillary services with a coinsurance or deductible amount may be billed by the facility. The service must not be rebilled.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03
0252	The modifier or the type of service submitted on this claim is inconsistent with authorized services.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N54	Claim information is inconsistent with pre-certified/authorized services.
0253	Wrong procedure code system is being billed.	CO	Contractual Obligations	**181**	**Payment adjusted because this procedure code was invalid on the date of service. Change 4/06.**	M51	Missing/incomplete/invalid procedure codes(s). Note: Modified 12-2-04 Related to N301
0254	The other insurance code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2-01	MA92	Missing plan information for other insurance. Note: Modified 2-1-04 Related to N245
0258	Invalid relationship between claim line COB value and claim line payment OR invalid relationship between COB values and total insurance paid.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0262	The beneficiary data on the Eligibility Verification System indicates other insurance. The provider should investigate to determine if benefits are available. The claim should be rebilled using the correct other insurance code and documentation.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0264	The discharge status code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA43	Missing/incomplete/invalid patient status. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0265	The discharge status code is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA43	Missing/incomplete/invalid patient status. Note: Modified 2-28-03
0269	The claim is being manually reviewed for possible change in other insurance status.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0271	The Medicaid Health Plan beneficiary has other insurance. The explanation code is for informational purposes only.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0276	The sum of the amounts paid by the other insurance carrier does not equal the total other insurance amount paid. The provider should recalculate the dollar amount on each claim line. The total of the other insurance payment on each claim line must equal the total other insurance payment item. The claim should be corrected and rebilled. (The provider may rebill indicating a lump sum other insurance payment in the Remarks section or Total Other Insurance Paid item. A copy of the other insurance's payment voucher must accompany the claim.)	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0277	The sum of the amounts billed does not equal the total amount billed. The provider should correct the dollar amounts on each claim line and rebill the claim.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0278	The noncovered charge is greater than the beneficiary-pay amount. The explanation code is for informational purposes only.	CO	Contractual Obligations	142	Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00	M79	Missing/incomplete/invalid charge. Note: Modifed 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0279	The claim line date of service is not included in the range of dates indicated by the from and thru dates on the claim. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: Modified 2-28-03
0280	The surgeon's provider ID Number is invalid.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N62	Missing/incomplete/invalid operating provider primary identifier. Note: New code 12-2-04
0282	The beneficiary-pay amount does not agree with the data on the Eligibility Verification System for this date of service. The beneficiary-pay amount for this beneficiary should be verified by the provider before billing another claim for this beneficiary. The explanation code is for informational purposes only.	CO	Contractual Obligations	142	Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00	N58	Missing/incomplete/invalid patient liability amount. Note: Modified 2-28-03
0284	State-owned and -operated facilities are not allowed to offset beneficiary-pay amounts. The service must not be rebilled.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N58	Missing/incomplete/invalid patient liability amount. Note: Modified 2-28-03
0287	State-owned and -operated ICF/MR (Provider Type 65) facilities may not bill for services that have been applied to the Medicare Part B deductible. The claim should not be rebilled.	CO	Contractual Obligations	**171**	**Payment is denied when performed/billed by this type of provider in this type of facility. Change 4/06.**	N95	This provider type/provider specialty may not bill this service. Note: New code 7-31-01, Modified 2-28-03
0288	The relationship between the claim status code and discharge status code is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA43	Missing/incomplete/invalid patient status. Note: Modified 2-28-03
0292	This beneficiary is not authorized for long-term care for these dates of service. The claim should not be rebilled.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0294	There is an invalid relationship between the claim line date of service and the number of days/quantity. The claim should be corrected and rebilled.	CO	Contractual Obligations	151	Payment adusted because the payer deems the information submitted does not support this many services. Note: New as of 10-02	M53	Missing/incomplete/invalid days or units of service. Note: Modified 2-28-03
0295	The claim status code is invalid or missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA43	Missing/incomplete/invalid patient status. Note: Modified 2-28-03
0296	The relationship between the claim status code and the admission begin date is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA40	Missing/incomplete/invalid admission date. Note: Modified 2-28-03
0298	The relationship between the Medicare indicator and the beneficiary's age is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	6	The procedure/revenue code is inconsistent with the patient's age. Note: Changed as of 6/02	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0299	Ancillary services may not be billed to Medicaid by state-owned and -operated ICF MR (Provider Type 65) facilities. The claim should not be rebilled.	CO	Contractual Obligations	96	Non-covered charge(s).	N95	This provider type/provider specialty may not bill this service. Note: New code 7-31-01 Modified 2-28-03
0300	Claim pended for manual review.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N45	Payment based on authorized amount.
0301	The relationship between the Adjustment Code (Type of Bill indicator) and the Original Claim Reference Number is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim. Note: Changed as of 6/03	M47	Missing/incomplete/invalid internal or document control number. Note: Modified 2-28-03
0302	Outpatient services for beneficiaries in a long-term care facility are limited to ancillary services. The service must not be rebilled.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03
0303	The Medicare indicator is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2-01	N36	Claim must meet primary payer's processing requirements before we can consider payment.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0306	Pharmacies cannot bill over-the-counter products that are included in the facility's per diem rate for a beneficiary in a long-term care facility. The service must not be rebilled.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents. Note: Modified 6-30-03
0308	Payment was forced for this enrollee who lost Medicaid eligibility for this month. The explanation code is for informational purposes only.	CO	Contractual Obligations	141	Claim adjustment because this claim spans eligible and ineligible periods of coverage. Note: Changed as of 6-00	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0309	The first date of service may not be a therapeutic leave day.	CO	Contractual Obligations	152	Payment adjusted because the payer deems the information does not support this length of service. Note: New as of 10-02	M52	Missing/incomplete/invalid “from” date(s) of service. Note: Modified 2-28-03
0310	The service is included in the long-term care facility's per diem rate.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents. Note: Modified 6-30-03
0313	The last date of service cannot be a therapeutic leave day.	CO	Contractual Obligations	152	Payment adjusted because the payer deems the information does not support this length of service. Note: New as of 10-02	M59	Missing/incomplete/invalid “to” date(s) of service. Note: Modified 2-28-03
0314	The coinsurance amount plus deductible amount is greater than the amount billed on the Medicare lines. The provider should verify the amount used with the Medicare voucher and correct and rebill the claim.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	M79	Missing/incomplete/invalid charge. Note: Modifed 2-28-03
0315	The date the claim was submitted to the other insurance carrier is invalid. The explanation code is for informational purposes only.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N245	Incomplete/invalid plan information for other insurance. Note: New code 8-1-04
0317	The relationship between the beneficiary's Level of Care and the provider type is invalid.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Changed as of 10/98	N95	This provider type/provider specialty may not bill this service. Note: New code 7-31-01 Modified 2-28-03
0319	This is a continuous or final billing for outpatient services.	CO	Contractual Obligations	45	Charges exceed your contracted/legislated fee arrangement.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0320	There is no Medicare payment or deductible on the claim and our records show there is Part B coverage.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	MA92	Missing plan information for other insurance. Note: Modified 2-1-04 Related to N245
0321	The procedure is being reviewed as a separate procedure.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N45	Payment based on authorized amount.
0322	The noncovered charges are not prior authorized. The service must not be rebilled.	CO	Contractual Obligations	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0323	Multiple procedures are being reviewed for appropriate reimbursement.	CO	Contractual Obligations	59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules. Note: Changed as of 6/00	N45	Payment based on authorized amount.
0324	Multiple procedures will be reimbursed based on claim line order with the primary procedure first.	CO	Contractual Obligations	59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules. Note: Changed as of 6/00	N45	Payment based on authorized amount.
0325	Multiple procedures are being reviewed for appropriate reimbursement.	CO	Contractual Obligations	59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules. Note: Changed as of 6/00	N45	Payment based on authorized amount.
0327	The appropriate CLIA lab specialty code is not on the Provider Enrollment file. The provider should notify Provider Enrollment, in writing, of its CLIA certification. The claim must not be rebilled until the Provider Enrollment file is updated.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Changed as of 10/98	MA120	Missing/incomplete/invalid CLIA certification number. Note: Modified 2-28-03
0328	The beneficiary is eligible for only Children's Special Health Care Services Program coverage and the service billed is not a benefit of that program. The service should not be rebilled.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03
0329	The number of days or visits is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	152	Payment adjusted because the payer deems the information submitted does not support this length of service. Note: New as of 10-02	M53	Missing/incomplete/invalid days or units of service. Note: Modified 2-28-03
0330	The number of days or visits is invalid.	CO	Contractual Obligations	152	Payment adjusted because the payer deems the information submitted does not support this length of service. Note: New as of 10-02	M53	Missing/incomplete/invalid days or units of service. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0331	The relationship between the number of days billed, the from and thru dates, and discharge status code is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	152	Payment adjusted because the payer deems the information submitted does not support this length of service. Note: New as of 10-02	N50	Missing/incomplete/invalid discharge information. Note: Modified 2-28-03
0332	The number of days billed in the From and Through dates does not equal the number of total days on the claim lines.	CO	Contractual Obligations	152	Payment adjusted because the payer deems the information submitted does not support this length of service. Note: New as of 10-02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0333	This procedure code cannot be used by this provider. The service should not be rebilled.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Changed as of 10/98	N95	This provider type/provider specialty may not bill this service. Note: New code 7-31-01, Modified 2-28-03
0334	Days supply is invalid or missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	154	Payment adjusted because the payer deems the information submitted does not support this day's supply. Note: New as of 10-02	M53	Missing/incomplete/invalid days or units of service. Note: Modified 2-28-03
0336	Days supply is greater than 100 days.	CO	Contractual Obligations	154	Payment adjusted because the payer deems the information submitted does not support this day's supply. Note: New as of 10-02	M53	Missing/incomplete/invalid days or units of service. Note: Modified 2-28-03
0337	The compounded indicator was changed to 1, as the value submitted was invalid. Valid values are 4 (home infusion therapy), 3 (compound for capsules, suppositories, and tissue papers), 2 (compound for other forms) and 1 (not a compound). The explanation code is for informational purposes only.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0338	The procedure code requires prior authorization when billed with this diagnosis.	CO	Contractual Obligations	11	The diagnosis is inconsistent with the procedure.	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0339	Replacement claim or adjustment pending for determination of compliance with prior authorization requirements.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0341	This laboratory service is not allowed for this provider type. The service must not be rebilled.	CO	Contractual Obligations	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Changed as of 6/02	N95	This provider type/provider specialty may not bill this service. Note: New code 7-31-01, Modified 2-28-03
0342	A unit dose fee has been approved for this provider. The explanation code is for informational purposes only.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0343	This procedure is being manually reviewed for identification of the referring/attending provider. The explanation code is for informational purposes only.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N286	Missing/incomplete/invalid referring provider primary identifier. Note: New code 12-2-04
0344	Required referring/attending provider ID Number is missing or invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N286	Missing/incomplete/invalid referring provider primary identifier. Note: New code 12-2-04
0348	This service has been reimbursed as a bilateral procedure based on the reporting of Modifier Code 50. The explanation code is for informational purposes only.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0349	Modifier Code 50 has been reported for this procedure, but no additional reimbursement has been made.The explanation code is for informational purposes only.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0350	Required place of service code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	5	The procedure code/bill type is inconsistent with the place of service.	M77	Missing/incomplete/invalid place of service. Note: Modified 2-28-03
0355	Required quantity billed is invalid or missing.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many services. Note: New as of 10-02	M53	Missing/incomplete/invalid days or units of service. Note: Modified 2-28-03
0362	Missing drug code. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Note: Modified 2-28-03
0363	Invalid drug code. The claim should be corrected and rebilled.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M119	Missing/incomplete/invalid/deactivated/ withdrawn National Drug Code (NDC). Note: Modified 2-28-03, 4-1-04
0364	The service has been rejected as it was rendered upon an order/prescription from a suspended provider. The claim must not be rebilled.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Changed as of 10/98	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New Code 12-2-04

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0367	The claim reflects a quantity in excess of the quantity normally accepted for this drug. This explanation code frequently causes payment rejections, because the proper billing unit was not used (e.g. milliliters were used instead of vials). Pharmacies should rebill with corrected quantity entries. When quantity limits are exceeded, a pharmacy may receive payment by rebilling and listing the prescriber's daily dosage instruction in the Remarks or Drug Description of the invoice. For dermatologicals, also list the size of the application area. [Note:The prescriber's daily dosage instruction, times the number of Days Supply billed, must equal the Quantity billed.]	CO	Contractual Obligations	153	Payment adjusted because the payer deems the information submitted does not support this dosage. Note: New as of 10-02	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Note: Modified 2-28-03
0368	Other insurance has reduced the amount approved to zero. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0369	The drug billed requires prior approval and the required prior authorization number was invalid for the beneficiary.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0370	The National Drug Code (NDC) is not on the Program's drug file. Check the NDC entry for accuracy and rebill.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M119	Missing/incomplete/invalid/deactivated/ withdrawn National Drug Code (NDC). Note: Modified 2-28-03, 4-1-04
0371	The National Drug Code (NDC) billed is not normally dispensed for a beneficiary of this age.	CO	Contractual Obligations	6	The procedure/revenue code is inconsistent with the patient's age. Note: Changed as of 6-02	M119	Missing/incomplete/invalid/deactivated/ withdrawn National Drug Code (NDC). Note: Modified 2-28-03, 4-1-04
0372	The National Drug Code (NDC) billed is not applicable for the beneficiary's sex. All data should be verified. If appropriate, corrections should be made and the claim rebilled. If the data is correct, the service must not be rebilled.	CO	Contractual Obligations	7	The procedure/revenue code is inconsistent with the patient's gender. Note: Changed as of 6-02	M119	Missing/incomplete/invalid/deactivated/ withdrawn National Drug Code (NDC). Note: Modified 2-28-03, 4-1-04
0373	The compounded drug claim is being manually priced.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N45	Payment based on authorized amount.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0374	The amount billed is being manually reviewed.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N45	Payment based on authorized amount.
0376	Medicaid, Children's Special Health Care Services or the Adult Benefits Waiver does not cover the drug billed. All data should be verified, especially the Michigan Medicaid Drug List (Appendix F). If appropriate, corrections should be made and the prescription rebilled. If the data is correct, the prescription must not be rebilled.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03
0377	The new/refill code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished, Note: Modified 2-28-03
0378	The new/refill code is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished, Note: Modified 2-28-03
0379	The fee for this procedure is being manually reviewed.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0380	The acquisition charge is missing.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N225	Incomplete/invalid documentation/ orders/notes/summary/report/chart. Note: Modified 8-1-05
0381	The facility charge is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M79	Missing/incomplete/invalid charge. Note: Modifed 2-28-03
0382	The quantity times the rate does not equal the hospital charge.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0383	The professional charge is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M79	Missing/incomplete/invalid charge. Note: Modifed 2-28-03
0384	The professional charge is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M79	Missing/incomplete/invalid charge. Note: Modifed 2-28-03
387	Invalid Title XVIII paid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M79	Missing/incomplete/invalid charge. Note: Modifed 2-28-03
0388	The diagnosis code does not appear to support the procedure billed.	CO	Contractual Obligations	11	The diagnosis is inconsistent with the procedure.	M76	Missing/incomplete/invalid diagnosis or condition. Note: Modified 2-28-03
0389	There is an invalid relationship between the number of days billed, the from and through dates, and the discharge status code.	CO	Contractual Obligations	152	Payment adjusted because the payer deems the information submitted does not support this length of service. Note: New as of 10-02	N50	Missing/incomplete/invalid discharge information. Note: Modified 2-28-03
0390	The other insurance payment on this claim line is invalid.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2-01	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
0392	The quantity entry and package size for the National Drug Code (NDC) billed are inconsistent. The pharmacy should check the quantity entry on the claim to make sure that decimals were billed for fractional package sizes (e.g. 18.1 gms) or that the quantity relates to the NDC package (e.g., billing 21, not 28, for an oral contraceptive sold in packages of 21).	CO	Contractual Obligations	153	Payment adjusted because the payer deems the information submitted does not support this dosage. Note: New as of 10-02	M123	Missing/incomplete,invalid name, strength, or dosage of the drug furnished. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0394	Inpatient hospital services for Wayne County Resident County Hospitalization beneficiaries require prior authorization by the Wayne County PLUS CARE Program.	CO	Contractual Obligations	38	Services not provided or authorized by designated (network/primary care) providers. Note: Changed as of 6-03	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0395	The amount billed on this claim line is missing.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M79	Missing/incomplete/invalid charge. Note: Modifed 2-28-03
0396	The charges minus Medicare and other insurance payment(s) do not equal the amount billed. The explanation code is for informational purposes only.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0397	The charges, minus Medicare and other insurance payment(s), do not equal the amount billed.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0398	Number of claim lines greater than 1.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N63	Rebill services on separate claim lines.
0400	The total number of lines is invalid. The explanation code is for informational purposes only.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N63	Rebill services on separate claim lines.
0401	The total number of lines is missing. The explanation code is for informational purposes only.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0402	The number of claim lines read does not equal the total number of lines indicated. The explanation code is for informational purposes only.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0403	The data on the Eligibility Verification System indicates other insurance. The provider should investigate to determine if benefits are available. The claim should be rebilled using the correct other insurance code and documentation.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0404	The claim is being manually reviewed for possible change in other insurance status.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0407	The data on the Eligibility Verification System indicates other insurance. The provider should investigate to determine if benefits are available. The claim should be rebilled using the correct other insurance code and documentation.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0408	The claim is being manually reviewed for possible change in other insurance status.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0409	The data on the Eligibility Verification System indicates other insurance. The provider should investigate to determine if benefits are available. The claim should be rebilled using the correct other insurance code and documentation.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0410	The Medicare payment is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N245	Incomplete/invalid plan information for other insurance. Note: New code 8-1-04
0411	The claim is being manually reviewed for possible change in other insurance status.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0412, 0413, 0414	Other insurance claim in process, did not wait reasonable amount of time to bill Medicaid.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0415	The Medicare coinsurance amount is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N245	Incomplete/invalid plan information for other insurance. Note: New code 8-1-04
0416	The amount billed as Medicare coinsurance is not calculated correctly based on the total Medicare payment.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0417	This elective service (Emergent Condition Code 2) was performed in the emergency room. The service should be rebilled using the clinic visit Procedure Code 169525.	CO	Contractual Obligations	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Changed as of 2/01	M77	Missing/incomplete/invalid place of service. Note: Modified 2-28-03
0418	This urgent service (Emergent Condition Code 3) was performed in the emergency room. The service should be rebilled using the clinic visit Procedure Code 169525.	CO	Contractual Obligations	58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note Changed as of 2/01	M77	Missing/incomplete/invalid place of service. Note: Modified 2-28-03
0420	The amount applied to the Medicare deductible exceeds the yearly Medicare deductible.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0421	The provider is billing a procedure code that is incompatible for the setting and the provider specialty.	CO	Contractual Obligations	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Changed as of 6/02	M77	Missing/incomplete/invalid place of service. Note: Modified 2-28-03
0422	A hospital charge is not allowed for this procedure, or the procedure performed is not indicated on the claim.	CO	Contractual Obligations	5	The procedure code/bill type is inconsistent with the place of service.	M51	Missing/incomplete/invalid procedure code(s). Modified 12-2-04 Related to N301
0423	The procedure code cannot be billed by the Outpatient Hospital. The provider must rebill using the correct claim form.	CO	Contractual Obligations	5	The procedure code/bill type is inconsistent with the place of service.	M51	Missing/incomplete/invalid procedure code(s). Modified 12-2-04 Related to N301
0424	This procedure code supports the hospital charge codes; no charge is allowed. The explanation code is for informational purposes only.	CO	Contractual Obligations	B15	Payment adjusted because this procedure/service is not paid separately. Note: Changed as of 2/01	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0425	The total other insurance paid is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N245	Incomplete/invalid plan information for other insurance. Note: New code 8-1-04
0426	Beneficiary not eligible for Medicaid and not covered for ABW because of county of residence. The provider should contact the beneficiary's health care or dental contractor.	CO	Contractual Obligations	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N30	Patient ineligible for this service. Note: Modified 6-30-03
0427	Beneficiary not eligible for Medicaid and not covered for ABW because of county of residence. The claim should not be rebilled.	CO	Contractual Obligations	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N30	Patient ineligible for this service. Note: Modified 6-30-03
0428	Beneficiary not eligible for Medicaid and not covered for ABW because of county of residence. The provider should contact the Wayne County Family Independence Agency office.	CO	Contractual Obligations	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N30	Patient ineligible for this service. Note: Modified 6-30-03
0429	Beneficiary not eligible for Medicaid and not covered for ABW because of county of residence. The claim must not be rebilled.	CO	Contractual Obligations	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N30	Patient ineligible for this service. Note: Modified 6-30-03
0432	The quantity billed is missing or invalid, or the outpatient hospital has asked for individual consideration.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many services. Note: New as of 10-02	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0433	The total charge is invalid or missing.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0434	The total Medicare payment is not numeric.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0435	The total facility charge is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0436	The sum of the total charges of each Revenue Code does not equal the total charges entered on line 23.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M50	Missing/incomplete/invalid revenue code(s). Note: Modified 2-28-03
0437	The sum of the claim line charges does not equal the total charge.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0438	The sum of the Medicare payments does not equal the total Medicare payments.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0439	The sum of the other insurance payments does not equal the total insurance payments	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement.:Changed 4-06**	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0440	The professional charges total is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0441	The sum of the professional charges does not equal the total professional charge.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0442	Wayne County RCH claim received after 10-31-89.	CO	Contractual Obligations	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N30	Patient ineligible for this service. Note: Modified 6-30-03

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0443	Beneficiary not eligible for Medicaid and not covered for ABW because of county of residence. The service must not be rebilled.	CO	Contractual Obligations	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N30	Patient ineligible for this service. Note: Modified 6-30-03
0444	Services may be the responsibility of the beneficiary's health care or dental contractor in the Wayne County PLUS CARE Program.	CO	Contractual Obligations	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. Note: Changed as of 6/00	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0445	The total payments from other sources is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0446	The drug requires prior approval and the prior authorization number is missing. The provider must obtain prior approval and enter the prior authorization number on the claim form.	CO	Contractual Obligations	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization. Note: Changed as of 2-01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0447	The beneficiary is a Qualified Medicare Beneficiary. This code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0448	Medicaid is liable only for the coinsurance and deductible portion of a Medicare-covered service for Qualified Medicare Beneficiaries. The claim must not be rebilled to Medicaid.	CO	Contractual Obligations	96	Non-covered charge(s).	N245	Incomplete/invalid plan information for other insurance. Note: New code 8-1-04
0450	The beneficiary-pay amount is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N58	Missing/incomplete/invalid patient liability amount. Note: Modified 2-28-03
0452	The claim is pending for manual review of the beneficiary-pay amount.	CO	Contractual Obligations	142	Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00	N58	Missing/incomplete/invalid patient liability amount. Note: Modified 2-28-03
0454	This service is not covered by the Program. The service must not be rebilled.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03
0456	The beneficiary-pay amount, less the noncovered charge, is not equal to the net beneficiary-pay amount.	CO	Contractual Obligations	142	Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00	N58	Missing/incomplete/invalid patient liability amount. Note: Modified 2-28-03

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0457	The claim is being reviewed as the place of service may not be acceptable for this surgery.	CO	Contractual Obligations	5	The procedure code/bill type is inconsistent with the place of service.	M77	Missing/incomplete/invalid place of service. Note: Modified 2-28-03
0462	The beneficiary is only eligible for emergency services and elective services have been billed. The service must not be rebilled.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care.	N30	Patient ineligible for this service. Note: Modified 6-30-03
0463	The primary physician's ID Number is not the same as the billing provider's ID Number or the referring/attending provider's ID Number on the claim. The provider should verify that the provider ID Number used on the claim is the primary physician's ID Number.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New Code 12-2-04
0465	The total amount billed is invalid.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0467	The total net charge, minus the net beneficiary-pay amount, does not equal the amount billed. The explanation code is for informational purposes only.	CO	Contractual Obligations	142	Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0468	The summary of the charges does not agree with the total amount billed.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0472	The Physician Sponsor's/Clinic Plan's Medicaid provider ID Number is not the same as the attending physician's provider ID Number on the claim. The provider should verify the attending physician's provider ID Number on the claim. If the number on the claim is incorrect, the provider should correct and rebill the claim. If the beneficiary was referred for medical care, the attending physician's provider ID Number must indicate the Physician Sponsor's/Clinic Plan's provider ID Number on the claim when billing. Medicaid will not cover services rendered to a Physician Sponsor/Clinic Plan beneficiary without the Physician Sponsor's/Clinic Plan's authorization unless the services were in response to an emergency situation.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New Code 12-2-04
0473	The beneficiary is enrolled in the Beneficiary Monitoring Program as requiring prior authorization for services.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0474	The beneficiary is enrolled in the Beneficiary Monitoring Restricted Provider Control Program and the provider ID Number is not the same as the provider or referring/attending/prescribing provider ID Number on the claim.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New Code 12-2-04
0480	The unit dose repackaging fee was not included in reimbursement because the prescription was not dispensed to a long-term care beneficiary OR the product is not an oral solid OR the product is a manufacturer prepackaged unit dose OR the pharmacy is not authorized for unit dose repackaging reimbursement. The explanation code is for informational purposes only.	CO	Contractual Obligations	153	Payment adjusted because the payer deems the information submitted does not support this dosage. Note: New as of 10-02	M123	Missing/incomplete,invalid name, strength, or dosage of the drug furnished. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0483	The beneficiary-pay amount has been corrected to match the amount on the Medicaid Eligibility File. If an insufficient beneficiary-pay amount has been collected, the balance is due from the beneficiary. If an excessive amount has been collected, the balance is due to the beneficiary. The explanation code is for informational purposes only.	CO	Contractual Obligations	142	Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00	N58	Missing/incomplete/invalid patient liability amount. Note: Modified 2-28-03
0486	The beneficiary no longer resides in the Medicaid Health Plan service area.	CO	Contractual Obligations	**177**	**Payment denied because the patient has not met the required eligibility requirements. Change 4/06.**	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.
0488	The Children's Special Health Care Services Program has not authorized this provider type to render services to this child.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Changed as of 10/98	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New Code 12-2-04
0489	The beneficiary is not eligible for Medicaid Health Plan enrollment.	CO	Contractual Obligations	31	Claim denied as patient cannot be identified as our insured.	N30	Patient ineligible for this service. Note: Modified 6-30-03
0492	The beneficiary was not eligible for Children's Special Health Care Services, Medicaid, State Medical Program, or Resident County Hospitalization coverage on the date(s) of service. The date(s) and beneficiary ID Number should be verified. If appropriate, the claim should be corrected and rebilled. If the data is correct, the service must not be rebilled.	CO	Contractual Obligations	31	Claim denied as patient cannot be identified as our insured.	N30	Patient ineligible for this service. Note: Modified 6-30-03
0494	The beneficiary was determined ineligible for Medical Assistance after a Medicaid ID Card was issued. Since a card was issued, the claim has been processed for payment. This also applies to the Adult Benefits Waiver Program in those counties where an ID Card is issued. The explanation code is for informational purposes only.	CO	Contractual Obligations	**31**	**Claim denied as patient cannot be identified as our insured. Change 4/06.**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0495	The beneficiary is over one year of age and is not enrolled in a Medicaid Health Plan or clinic plan on the date of service.	CO	Contractual Obligations	**177**	**Payment denied because the patient has not met the required eligibility requirements. Change 4/06.**	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0497	This claim line is paid at 50% of the provider's charge or at 50% of Medicaid reimbursement, whichever is less. The explanation code is for informational purposes only.	CO	Contractual Obligations	**172**	**Payment is adjusted when performed/billed by a provider of this specialty. Change 4/06.**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0498	This service must be billed with a modifier. The claim should be rebilled with the appropriate modifier.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier. Note: Modified 2-28-03
0500	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.	CO	Contractual Obligations	59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules. Note: Changed as of 6/00	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0501	Duplicate procedure between HCPCS and old procedure coding.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	M84	Medical code sets used must be the codes in effect at the time of service. Note: Modified 2-1-04
0503	The date of service on the claim requires manual review. Adjustments will be processed manually.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0504	Date of claim is too old for immediate computer processing.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0505	The dates of service span two or more historical processing periods. Each date of service must be rebilled on a separate claim.	CO	Contractual Obligations	138	Claim/service denied. Appeal procedures not followed or time limits not met. Note: New as of 6/99	N302	Missing/incomplete/invalid other procedure date(s). Note: New code 12-2-04
0506	The services do not reflect the provision of nursing or physical therapy services.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N225	Incomplete/invalid documentation/ orders/notes/summary/report/chart. Note: Modified 8-1-05
0508	Date of Service for Medicaid Health Plan (MHP) claim is too old to be processed.	CO	Contractual Obligations	138	Claim/service denied. Appeal procedures not followed or time limits not met. Note: New as of 6/99	N301	Missing/incomplete/invalid procedure dates(s). Note: New Code 12-2-04
0510	The claim indicates a possible DRG overpayment.	CO	Contractual Obligations	45	Charges exceed your contracted/legislated fee arrangement.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0511	The claim indicates an admission to the hospital within 15 days of discharge from a different hospital.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N47	Claim conflicts with another inpatient stay.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0513	The claim indicates a readmission to the same hospital within 15 days of discharge. The claim should be rebilled as explained in the Medicaid Hospital Manual.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	N47	Claim conflicts with another inpatient stay.
0515	The outpatient claim indicates emergency room services (Procedure Code 169032 or revenue code 450) and subsequent admission to the inpatient hospital setting.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	N47	Claim conflicts with another inpatient stay.
0517	Inpatient Hospital claim was not processed by the groups/prices. The explanation code is for informational purposes only.	CO	Contractual Obligations	A6	Prior hospitalization or 30 day transfer requirement not met.	N47	Claim conflicts with another inpatient stay.
0518	This beneficiary was admitted/hospitalized within 15 days of discharge from a different hospital.	CO	Contractual Obligations	A6	Prior hospitalization or 30 day transfer requirement not met.	N47	Claim conflicts with another inpatient stay.
0519	This beneficiary was readmitted/rehospitalized to the same hospital within 15 days of discharge.	CO	Contractual Obligations	A6	Prior hospitalization or 30 day transfer requirement not met.	N47	Claim conflicts with another inpatient stay.
0526	The documentation submitted does not reflect the diagnosis and/or procedure as indicated on the claim. The claim has been reassigned to a new DRG.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N225	Incomplete/invalid documentation/ orders/notes/summary/report/chart. Note: Modified 8-1-05
0530	The outpatient claim is for services provided during an inpatient stay. These outpatient services must be included on the inpatient claim. The outpatient hospital must contact the inpatient hospital for reimbursement for these services.	CO	Contractual Obligations	60	Charges for outpatient services with this proximity to inpatient services are not covered.	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
0532	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0534	The total of the beneficiary-pay amount on all long-term care invoices for this beneficiary for this month of service exceeds the beneficiary-pay amount shown on the Eligibility Verification System. The explanation code is for informational purposes only. The provider should refund the excess beneficiary-pay amount to the beneficiary and submit a claim adjustment.	CO	Contractual Obligations	142	Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00	N58	Missing/incomplete/invalid patient liability amount. Note: Modified 2-28-03
0535	The total of the beneficiary-pay amount on all long-term care invoices for this beneficiary for this month of service is less than the beneficiary-pay amount shown on the Eligibility Verification System. The Department of Community Health has corrected the beneficiary-pay amount on this claim to reflect the beneficiary-pay amount shown on the Eligibility Verification System for the month.	CO	Contractual Obligations	142	Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00	N58	Missing/incomplete/invalid patient liability amount. Note: Modified 2-28-03
0536	The amount billed for this laboratory service exceeds the dollar limitation established by the Program.	CO	Contractual Obligations	23	Payment adjusted because charges have been paid by another payer. Note: Changed 4-06	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0538	The amount billed for this laboratory service exceeds the dollar limitation established by the Program.	CO	Contractual Obligations	23	Payment adjusted because charges have been paid by another payer. Note: Changed 4-06	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0540	Beneficiary enrolled in Healthy Kids Dental Program. Submit claim to the dental carrier. Do not rebill the Medicaid Program.	CO	Contractual Obligations	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N30	Patient ineligible for this service. Note: Modified 6-30-03
0544	Physician ER case rate: services provided in an emergency room, and subject to the ER case rate payment, have been billed on separate invoices. This claim has been pended for review.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	M85	Subjected to review of physician evaluation and management services.
0545	Rental converted to purchase.	CO	Contractual Obligations	108	Payment adjusted because rent/purchase guidelines were not met. Note: Changed as of 6/02	M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0548	The claim is a duplicate of a previously paid claim. The Claim Reference Number, line number, and payment date of the paid claim are shown. (If the Claim Reference Number following Explanation Code 548 is the same as the number assigned to this claim in the left column on the Remittance Advice, duplicate services are billed on this claim.)	CO	Contractual Obligations	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: Modified 6-30-03
0549	The claim is a duplicate of a claim paid to another Medicaid Health Plan.	CO	Contractual Obligations	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: Modified 6-30-03
0552	The claim is a duplicate of a previously paid claim. The Claim Reference Number, line number, and payment date of the paid claim are shown. (If the Claim Reference Number following Explanation Code 552 is the same as the number assigned to this claim in the left column on the Remittance Advice, duplicate services are billed on this claim.)	CO	Contractual Obligations	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: Modified 6-30-03
0553	The frequency of this service is being manually reviewed.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many services. Note: New as of 10-02	N45	Payment based on authorized amount.
0555	The date(s) of service is invalid.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N301	Missing/incomplete/invalid procedure dates(s). Note: New code 12-2-04
0560	A claim is on file with a different drug entity for the same beneficiary and prescription number. The explanation code is for informational purposes only.	CO	Contractual Obligations	18	Duplicate claim/service.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0562	Refills of Schedule II drugs are not covered. The prescription must not be rebilled.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03
0563	A refill for a Schedule III, IV, or V drug was billed more than 180 days from the date of service of the original prescription. A new prescription is required.	CO	Contractual Obligations	29	The time limit for filing has expired.	M79	Missing/incomplete/invalid charge. Note: Modifed 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0565	The claim is billing for the sixth refill of the prescription for a Schedule III, IV, or V drug. Only five refills are allowed. A new prescription must be obtained before the prescription is rebilled.	CO	Contractual Obligations	96	Non-covered charge(s).	M79	Missing/incomplete/invalid charge. Note: Modifed 2-28-03
0567	The beneficiary has received the same drug from two different pharmacies within a short period of time. The explanation code is for informational purposes only.	CO	Contractual Obligations	18	Duplicate claim/service.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0571	The dates of service for this inpatient claim overlap the dates of service for another paid claim and the amounts billed are equal.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N47	Claim conflicts with another inpatient stay.
0572	This is a duplicate claim paid to the same Medicaid Health Plan for the same beneficiary and the same date(s) of service. The Claim Reference Number and payment date of the paid claim are shown. (If the Claim Reference Number following Explanation Code 572 is the same as the number assigned to this claim in the left column on the Remittance Advice, duplicate services are billed on this claim.) The service must not be rebilled.	CO	Contractual Obligations	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: Modified 6-30-03
0574	The Medicaid Health Plan invoice dates of service overlap the dates of the previously paid claim to another type of provider.	CO	Contractual Obligations	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: Modified 6-30-03
0575	The dates of services for this claim are duplicate or overlapping the dates of service for another paid claim.	CO	Contractual Obligations	18	Duplicate claim/service.	N20	Service not payable with other service rendered on the same date.
0576	The payment of this Medicare deductible would result in overpayment of the Medicare deductible for the year.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0577	More than 18 therapeutic leave days have been used in the last 365 days.	CO	Contractual Obligations	152	Payment adjusted because the payer deems the information submitted does not support this length of service. Note: New as of 10-02	N43	Bed hold or leave days exceeded.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0578	Billing for more than ten (10) Hospital Leave days.	CO	Contractual Obligations	152	Payment adjusted because the payer deems the information submitted does not support this length of service. Note: New as of 10-02	N43	Bed hold or leave days exceeded.
0579	The sum of all beneficiary-pay amounts accumulated by this payment system, for this beneficiary, for this month of service, does not equal the beneficiary-pay amount on the system. This explanation code applies to claim adjustments only. If the claim is rejected, correct the beneficiary's patient-pay amount and rebill the adjustment.	CO	Contractual Obligations	142	Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00	N58	Missing/incomplete/invalid patient liability amount. Note: Modified 2-28-03
0581	The claim to be adjusted/replaced cannot be located as a paid claim for this beneficiary.	CO	Contractual Obligations	17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N29	Missing documentation/orders/notes/ summary/ report/chart. Note: Modified 8-1-05
0582	An attempt was made to adjust/replace a Claim Reference Number or line number which has already been adjusted/replaced. Only the last paid Claim Reference Number/line number can be adjusted. The claim adjustment should be rebilled using the last paid Claim Reference Number.	CO	Contractual Obligations	107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim. Note: Changed as of 6/03	N225	Incomplete/invalid documentation/orders/notes/summary/ report/chart. Note: Modified 8-1-05
0584	This is the Claim Reference Number of the claim being adjusted/replaced. The explanation code is for informational purposes only.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA67	Correction to a prior claim.
0589	This fiscal year has been final gross adjusted.	CO	Contractual Obligations	45	Charges exceed your contracted/legislated fee arrangement.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0590	The acute dosing coverage for ulcer drugs has been exceeded and no Utilization Review Number has been submitted with the request for payment. The service must not be rebilled.	CO	Contractual Obligations	153	Payment adjusted because the payer deems the information submitted does not support this dosage. Note: New as of 10-02	N35	Program integrity/utilization review decision.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0592	Duplicate claims between group ID's.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	M80	Not covered when performed during the same session/date as a previously processed service for the patient. Note: Modified 2-1-04
0593	More than one provider type has billed for this service.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	M80	Not covered when performed during the same session/date as a previously processed service for the patient. Note: Modified 2-1-04
0596	More than one provider type has billed for case management for the same month. The explanation code is for informational purposes only.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0600	Determination of reimbursement for the DRG is being made. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charges exceed your contracted/legislated fee arrangement.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0601	This service may have a comprehensive/component or a mutually exclusive relationship with another service paid for the same date.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0602	This service has a comprehensive/component or a mutually exclusive relationship with another service paid for the same date.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	M80	Not covered when performed during the same session/date as a previously processed service for the patient. Note: Modified 2-1-04
0603	This service may have a comprehensive/component or a mutually exclusive relationship with another service paid for the same date.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0604	This service has a comprehensive/component or a mutually exclusive relationship with another service paid for the same date.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	M80	Not covered when performed during the same session/date as a previously processed service for the patient. Note: Modified 2-1-04
0606	Multiple procedures or services have been billed on separate claims.	CO	Contractual Obligations	B15	Payment adjusted because this procedure/service is not paid separately. Note: Changed as of 2/01	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0607	The frequency of the combination of services billed exceeds Program policy limits. The services must not be rebilled.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0608	The frequency of the combination of services billed exceeds Program Policy Limits. Medical necessity must be documented.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many services. Note: New as of 10-02	M42	The medical necessity form must be personally signed by the attending physician.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0609	The frequency of the combination of services billed exceeds Program Policy Limits. Medical necessity must be documented.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many services. Note: New as of 10-02	M42	The medical necessity form must be personally signed by the attending physician.
0630	Submission of duplicate value code.	CO	Contractual Obligations	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded. Note: Changed as of 2/02	M49	Missing/incomplete/invalid value code(s) or amount(s). Note: Modified 2-28-03
0633	Out of state provider is not billing for emergency services, Medicare coninsurance/deductibles or prior authorized services	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N35	Program integrity/utilization review decision.
0638	**Invalid TOB. Effective Dat: May 2006**	**CO**	**Contractual Obligations**	**5**	**The procedure code/bill type is inconsistent with the place of service**	**MA30**	**Missing/incomplete/invalid type of bill.**
0640	Claim is missing other insurance payment.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2-01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0641	Claim replacement is being manually reviewed.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	MA67	Correction to a prior claim.
0651	The amount approved has been reduced due to maximum fee screens.	CO	Contractual Obligations	23	Payment adjusted because charges have been paid by another payer. Note: Changed 4-06	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0652	Service line or claim rejection has reduced the amount approved to zero.	CO	Contractual Obligations	23	Payment adjusted because charges have been paid by another payer. Note: Changed 4-06	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0653	The hospital claim's DRG has caused the amount approved to be greater than the charges.	CO	Contractual Obligations	23	Payment adjusted because charges have been paid by another payer. Note: Changed 4-06	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0654	The hospital claims's DRG, per diem, or percent of charge reimbursement is less than the charges.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0655	The amount approved is reduced due to the patient payment.	CO	Contractual Obligations	142	Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0656	The amount approved is reduced due to the other insurance and Medicare payments on the claim.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0666	Date of death is before the date of service.	CO	Contractual Obligations	13	The date of death precedes the date of service.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0667	Service not covered because beneficiary was incarcerated on the date of service.	CO	Contractual Obligations	96	Non-covered charge(s).	N103	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt. Note: Modified 6-30-03
0668	The Claim Adjustment Reason Codes supplied by the prior payer have caused the reimbursement amount to be affected (this code will not be reported on the 835).	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2-01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0669	Claim is being adjusted because the date of service is after the date of death.	CO	Contractual Obligations	13	The date of death precedes the date of service.	N185	Do not resubmit this claim/service. Note: New code 2-28-03
0670	Beneficiary has private coverage through a managed care organization (MCO). You must bill that MCO. If you are not part of that network you must obtain authorization from that MCO before billing. Medicaid and CSHCS will only cover the co-payment and deductible up to the Medicaid fee.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0671	The insurance carrier indicates that you are a participating provider and have agreed to accept their payment as payment in full. Medicaid and CSHCS will not make further payment and the client may not be billed.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.
0672	The beneficiary has met their private insurance co-pay requirement limit for the year. You may bill and receive full reimbursement from the insurance carrier.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0673	This service is a covered benefit under the private insurance policy of the beneficiary but, to be reimbursed, it requires you to bill the insurance carrier using a more specific diagnosis.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	M81	You are required to code to the highest level of specificity. Note: Modified 2-1-04
0674	This service is a covered benefit under the private insurance policy of the beneficiary. Bill the insurance carrier.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0675	The reason the insurance carrier rejected this claim is not clear. Re-bill with a copy of the EOB or include a detailed rejection description.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N4	Missing/incomplete/invalid prior insurance carrier EOB. Note: Modified 2-28-03
0676	The insurance carrier included payment for this service in another procedure performed on the same day. Re-bill both procedures reflecting the appropriate distribution of the insurance payment.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Changed 4-06**	N20	Service not payable with other service rendered on the same date.
0677	The beneficiary has a point of service insurance policy. Medicaid requires that the beneficiary use the highest level of benefit available (e.g. using a network provider rather than paying a higher co-pay). Medicaid will not make further payment for this service.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N185	Do not resubmit this claim/service. Note: New code 2-28-03
0678	Based on the insurance payment, we have adjusted our payment for the service to include only the co-pay and deductible.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Chagned 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0679	The service was denied by the insurance carrier for a pre-existing condition. Sufficient credible coverage exists under the Medicaid and/or CSHCS Programs to require the carrier to pay for the service. A Certificate of Credible Coverage will be sent to you under a separate cover letter. Include this certificate with your re-billing to the carrier.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0680	Claim adjusted because client was incarcerated during the date of service	CO	Contractual Obligations	96	Non-covered charge(s).	N103	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt. Note: Modified 6-30-03
0682	The Michigan Medicaid Nursing Facility Level of Care Determination electronic assessment was not found for this beneficiary. This claim has been rejected.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N146	Missing screening document. Note: Modified 8-1-04. Related to N243
0683	This claim is rejected because: The electronic Michigan Medicaid Nursing Facility Level of Care (LOC) Determination electronic assessment was not found for this beneficiary, or the LOC Determination was done, but the beneficiary was determined not eligible for nursing facility level of services, or the LOC Determination was done, but not within 14 days of admission, or the screening was done, but the facility did not enter the beneficiary's Medicaid ID number in the on-line LOC Determination. In this case, the facility can enter the ID number in the on-line LOC Determination by going to the Determination Welcome Screen, select "ADD BENEFICIARY ID" and then rebill the claim. Description expanded 6-06.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Added 11-1-05	N146	Missing screening document.
0690	This claim has been re-entered/created by the Department of Community Health. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charges exceeded your contracted/legislated fee arrangement.	MA67	Correction to a prior claim.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0691	This claim has been re-entered/created by the Department of Community Health. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charges exceeded your contracted/legislated fee arrangement.	MA67	Correction to a prior claim.
0693	The beneficiary's eligibility has been manually reviewed. The explanation code is for informational purposes only.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0694	The beneficiary's eligibility has been manually reviewed. The explanation code is for informational purposes only.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0695	The beneficiary's eligibility has been manually reviewed. The explanation code is for informational purposes only.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0696	The beneficiary's eligibility has been manually reviewed. The explanation code is for informational purposes only.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0697	The beneficiary's eligibility has been manually reviewed. The explanation code is for informational purposes only.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0698	The beneficiary's eligibility has been manually reviewed. The explanation code is for informational purposes only.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0699	The beneficiary's eligibility has been manually reviewed. The explanation code is for informational purposes only.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Rev 5-16-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0700	The reimbursement amount was manually determined. The explanation code is for informational purposes only.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N45	Payment based on authorized amount.
0701	A portion or all of the outlier days have been denied. The claim has been adjusted accordingly.	CO	Contractual Obligations	152	Payment adjusted becauyse the payer deems the information submitted does not support this length of service. Note: New as of 10-02	MA32	Missing/incomplete/invalid number of covered days during the billing period. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0702	The quantity has been corrected to correspond with the procedure code description and submitted documentation. In the future, the quantity field must be completed with the correct quantity. The explanation code is for informational purposes only. OR The quantity of visits has been changed to reflect those on the submitted beneficiary care plan of treatment. For payment to be considered for additional visits, a claim adjustment is required with documentation supporting the necessity for the additional visits.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many services. Note: New as of 10-02	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0703	Medicaid is only responsible for the Medicare 20% coinsurance amount for those beneficiaries eligible for Medicare Part B for a total amount not to exceed Medicaid's reimbursement limitation.The claim has been processed for this amount up to Medicaid's maximum limitation. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0704	The maximum allowance for this service has been paid. For inpatient hospitals, any change in the charges will be manually reflected in the final settlement data. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0705	A computational error has been corrected and the total amount billed has been processed accordingly. The explanation code is for informational purposes only.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0706	For Inpatient Hospital: The beneficiary's patient-pay amount, according to the Eligibility Verification System, is less than the amount reflected on the claim. If you have collected an inappropriate beneficiary-pay amount, the difference should be refunded to the beneficiary. The explanation code is for informational purposes only. For Long-Term Care: The total of the beneficiary-pay amount on all long-term care invoices for this beneficiary for this month of service is less than the beneficiary-pay amount on the Eligibility Verification System. The Department of Community Health has corrected the beneficiary-pay amount on this claim to reflect the beneficiary-pay amount shown on the Eligibility Verification System for the month.	CO	Contractual Obligations	142	Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00	N58	Missing/incomplete/invalid patient liability amount. Note: Modified 2-28-03
0707	The service on this claim line has been recoded to the correct procedure/type/drug code. The provider must use the corrected code for future billings. The explanation code is for informational purposes only.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301
0708	The utilization review sheet, discharge summary, anesthesia report, or admission history and physical was either not received or incomplete. The claim should be rebilled with the appropriate documentation	CO	Contractual Obligations	17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N29	Missing documentation/orders/notes/ summary/ report/invoice. Note: Modified 2-28-03 Related to N225
0709	A PACER number must be obtained before this claim can be paid. Provider must obtain PACER number and enter it on the claim form.	CO	Contractual Obligations	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0710	The documentation submitted for review of this admission does not warrant a second DRG payment. The provider should include the services for this admission on the claim for the first admission. If the first admission has been paid, then these services must be included on a claim adjustment for the first admission.	CO	Contractual Obligations	150	Payment adjusted because the payer deems the information submitted does not support this level of service. Note: New as of 10-02	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0711	The Optical Character Reader could not read the typed print properly. This may be corrected by cleaning the type font, changing the ribbon, or properly aligning the claim. The explanation code is for informational purposes only.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N205	Information provided was illegible. Note: New code 6-30-03
0712	A review of this readmission appears to warrant two separate DRGs. A claim for each admission must be submitted, along with the required documentation attached to each claim.	CO	Contractual Obligations	B22	This payment is adjused based on the diagnosis. Note: Changed as of 2/01	N45	Payment based on authorized amount.
0713	The claim has been manually rejected. A separate cover letter has been sent to the provider explaining the reason for this rejection.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N29	Missing documentation/orders/notes/ summary/ report/chart. Note: Modified 8-1-05
0714	The documentation is not adequate to warrant additional payment for this service. If appropriate, a claim adjustment should be submitted with complete documentation of the service provided. The explanation code is for informational purposes only.	CO	Contractual Obligations	150	Payment adjusted because the payer deems the information submitted does not support this level of service. Note: New as of 10-02	M69	Paid at the regular rate as you did not submit documentation to justify the modified procedure code. Note: Modified 2-1-04
0715	Claims should be rebilled with the actual product cost of the item documented. The explanation code is for informational purposes only.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N29	Missing documentation/orders/notes/ summary/ report/chart. Note: Modified 8-1-05

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0716	This claim was rejected in error and has been resubmitted by the Department of Community Health. The explanation code is for informational purposes only.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N45	Payment based on authorized amount.
0717	The provider type code and/or provider ID Number were corrected. In the future, this information must be completed properly. The explanation code is for informational purposes only.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New Code 12-2-04
0718	This claim has been corrected to correspond with information on the prior authorization form. The explanation code is for informational purposes only.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0719	Reimbursement for this Medicare Part A only claim includes a full DRG payment minus the coinsurance and/or deductible payments previously paid on the Part B only claim. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0720	The diagnosis code has been corrected to correspond with the diagnosis description. The explanation code is for informational purposes only.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA63	Missing/incomplete/invalid principal diagnosis. Note: Modified 2-28-03
0721	The Medicare status code has been corrected. The explanation code is for informational purposes only.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0722	The date of service has been corrected to the proper eight (8)-digit format. The explanation code is for informational purposes only.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N301	Missing/incomplete/invalid procedure dates(s). Note: New Code 12-2-04

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0723	The frequency of this service exceeds Program parameters. Medical necessity must be documented. The explanation code is for informational purposes only.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many services. Note: New as of 10-02	N225	Incomplete/invalid documentation/orders/notes/summary/ report/chart. Note: Modified 8-1-05
0724	The information on this claim does not adequately support the use of Emergent Condition Code 1 (emergency). If appropriate, the claim should be rebilled with complete documentation supporting the Emergent Condition Code 1.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care.	MA41	Missing/incomplete/invalid admission type. Note: Modified 2-28-03
0725	This procedure, reviewed under Explanation Code 087, has been rejected. Having been previously advised of a provider's right to contest this decision, the provider may wish to address a request for an Administrative Hearing to the Manager, Administrative Tribunal and Appeals Division, PO Box 30195, Lansing, MI 48909-7695.	CO	Contractual Obligations	150	Payment adjusted because the payer deems the information submitted does not support this level of service. Note: New as of 10-02	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301
0727	This claim has been manually rejected for reasons specified by the accompanying explanation codes with "P" (pend) indicators.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N225	Incomplete/invalid documentation/orders/notes/summary/ report/chart. Note: Modified 8-1-05
0728	This rejected claim will be paid with a gross adjustment in accordance with the provisions of a letter forwarded under separate cover to the address indicated on page 1 of the Remittance Advice. The claim should not be rebilled.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M118	Letter to follow containing further information.
0729	This service has been billed on the wrong claim form. The provider should refer to his/her provider manual for the correct claim form to use and rebill the claim.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N34	Incorrect claim form for this service.
0730	Mutually exclusive services have been billed separately and payment is not allowed. These procedures must be combined and rebilled on one claim line, using the appropriate procedure code.	CO	Contractual Obligations	18	Duplicate claim/service.	N20	Service not payable with other service rendered on the same date.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0731	Service not payable with other service rendered on the same date. The service must not be rebilled.	CO	Contractual Obligations	18	Duplicate claim/service.	N20	Service not payable with other service rendered on the same date.
0732	This service is included in the reimbursement for the medical visit provided on the same date of service. The service must not be rebilled.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: Modified 6-30-03
0733	There is not sufficient information to process this claim line. The claim line should be rebilled with complete documentation to support the service provided. If claim adjusting, a copy of the Remittance Advice page showing the last payment must also be attached.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N225	Incomplete/invalid documentation/orders/notes/summary/ report/chart. Note: Modified 8-1-05
0734	The quantity billed on this line is not consistent with the billing unit specified in the Michigan Pharmaceutical Product List (MPPL). The claim should be billed with the correct quantity as specified in the MPPL.	CO	Contractual Obligations	154	Payment adjusted because the payer deems the information submitted does not support this dosage. Note: New as of 10-02	M53	Missing/incomplete/invalid days or units of service. Note: Modified 2-28-03
0735	Multiple services are combined on one claim line. Each service should be rebilled on a separate claim line.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M54	Missing/incomplete/invalid total charges. Note: Modified 2-28-03
0736	This service is included in the surgical fee/delivery fee/antepartum fee. The service must not be rebilled.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
0737	Beneficiary ineligible for this service. The service must not be rebilled.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03
0738	This service is included as a component part of another service and cannot be reimbursed separately. The service must not be rebilled.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: Modified 6-30-03
0739	The procedure code/procedure type code/drug code on this claim line should be rebilled with the correct code. (The provider should also review the combination of procedure type code and place of service code.) The claim should be corrected and rebilled.	CO	Contractual Obligations	5	The procedure code/bill type is inconsistent with the place of service.	M51	Missing/incomplete/invalid procedure code(s). Note: Modified 12-2-04 Related to N301

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0740	This service must be rebilled with a copy of the operative report, pathology report, or office or progress notes. The claim should be rebilled with the appropriate documentation.	CO	Contractual Obligations	17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N225	Incomplete/invalid documentation/orders/notes/summary/ report/chart. Note: Modified 8-1-05
0741	This payment reflects the maximum Medicaid allowance minus the other insurance payment indicated on the claim. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 2-01; update 4-06**	N45	Payment based on authorized amount.
0742	The surgical procedures should be rebilled according to Program guidelines, in the proper sequence (indicating the primary procedure on the first claim line), with appropriate modifiers. The claim should be corrected and rebilled.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N232	Incomplete/invalid itemized bill. Note: New code 8-1-04
0743	This claim has been manually rejected due to technical reasons. The provider should not submit a new claim. The Department of Community Health will re-enter the claim. It will be processed under a new Claim Reference Number and will appear on a future Remittance Advice.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA67	Correction to a prior claim.
0744	Missing provider signature. A signed claim should be rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA70	Missing/incomplete/invalid provider representative signature. Note: Modified 2-28-03
0745	The drug listed on the claim cannot be paid without additional information, including the manufacturer, National Drug Code, and dose (quantity given). The invoice from the manufacturer, wholesaler, or pharmacy must be attached to the rebilled claim.	CO	Contractual Obligations	153	Payment adjusted because the payer deems the information submitted does not support this dosage. Note: New as of 10-02	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0746	This service cannot be series billed. Each date of service must be rebilled on separate claim lines.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N63	Rebill services on separate claim lines.
0747	Only one initial consultation or comprehensive exam is allowed within a six month period.	CO	Contractual Obligations	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded. Note: Changed as of 2-01	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: Modified 6-30-03
0748	Services performed for the reported diagnosis code are not reimbursable due to the age or sex of the beneficiary. The service must not be rebilled.	CO	Contractual Obligations	11	The diagnosis is inconsistent with the procedure.	MA63	Missing/incomplete/invalid principal diagnosis. Note: Modified 2-28-03
0749	The pharmacy should recheck that the correct metric-billing unit, as listed in the Michigan Pharmaceutical Product List (MPPL), was used for the Quantity entry. Drug quantity exceeding the Department of Community Health's established allowable amounts must be fully documented by “daily dosage instructions.” The claim should be rebilled with the appropriate documentation or corrected metric billing units.	CO	Contractual Obligations	153	Payment adjusted because the payer deems the information submitted does not support this dosage. Note: New as of 10-02	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Note: Modified 2-28-03
0750	Reimbursement cannot be determined for this product without additional information, such as product name, manufacturer, National Drug Code or product number, dosage, form, strength, and quantity dispensed. The claim should be rebilled with complete documentation.	CO	Contractual Obligations	153	Payment adjusted because the payer deems the information submitted does not support this dosage. Note: New as of 10-02	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Note: Modified 2-28-03
0751	Medicaid records do not verify that the beneficiary-pay amount has been collected for this month of service. The service must first be applied to the beneficiary's patient-pay amount. Any services that are not covered by this amount may be rebilled.	CO	Contractual Obligations	142	Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00	N58	Missing/incomplete/invalid patient liability amount. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0752	Medicaid records show this beneficiary was deceased during this period. The claim should be rebilled for services rendered prior to date the beneficiary expired.	CO	Contractual Obligations	13	The date of death precedes the date of service.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: Modified 2-28-03
0753	Emergency condition not sufficiently documented. Provider should supply more documentation and resubmit.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care.	N225	Incomplete/invalid documentation/orders/notes/summary/ report/chart. Note: Modified 8-1-05
0754	The only noncovered services rejected by Medicare that can be billed to Medicaid are those specifically identified as Medicare exclusions. The provider should contact Medicare to determine the reason for the Medicare rejection. If the claim was rejected by Medicare because: Ø The service was billed incorrectly to Medicare, the provider should rebill Medicare. Ø The service was not medically necessary, Medicaid will not reimburse for the service. Ø The service is not a Medicare covered service, the provider may rebill Medicaid. The service must be rebilled on a separate claim. Only Medicare excluded services should be included on the claim.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0755	Those services covered by Medicare cannot be combined on one claim with services not covered by Medicare. The provider must bill covered Medicare services on one claim and Medicare noncovered services on a second claim with the appropriate Medicare status code on each claim.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0756	The payment information on the claim is inconsistent with the Medicare EOB.The claim should be corrected and rebilled.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N4	Missing/incomplete/invalid prior insurance carrier EOB. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0757	An invoice cannot be submitted to adjust a previous payment. Proper claim adjustment procedures must be followed as specified in Chapter IV of the manual.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: Modified 6-30-03
0758	This claim adjustment or replacement cannot be processed because some or all of the information does not match the original claim. A claim adjustment must match the last paid claim for the following items: provider ID Number, beneficiary ID Number, Claim Reference Number, and claim line number. The claim adjustment should be corrected and rebilled. NOTE:A rejected claim cannot be claim adjusted, but requires submission of a new claim. Also, for purposes of claim adjusting, a claim that indicated a $0.00 payment is considered a paid claim.	CR	Correction and Reversals	129	Payment denied - Prior processing information appears incorrect. Note: Changed as of 2/01	N152	Missing/incomplete/invalid replacement claim information. Note: New code 10-31-02
0759	Series billing on any one claim line cannot encompass services rendered in more than one calendar month. The last date in the month that the service was rendered must be used. The claim should be rebilled indicating one calendar month per claim line. Note: For long-term care-facilities: When billing for more than one month of service, each month must be submitted on separate claims.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
0760	This service requires prior authorization. Since prior authorization was not obtained, the service is not covered by Medicaid. The beneficiary, his/her family, or representative must not be billed for this service.	CO	Contractual Obligations	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0761	The necessary documentation was not received. The claim should be rebilled with appropriate, complete, legible documentation.	CO	Contractual Obligations	17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N29	Missing documentation/orders/notes/ summary/ report/chart. Note: Modified 8-1-05
0762	The submitted documentation was not adequate or not legible. The claim should be rebilled with complete, legible documentation.	CO	Contractual Obligations	17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N205	Information provided was illegible. Note: New code 6-30-03
0763	The date of service is more than 12 months old and the Department of Community Health is unable to verify previous activity. If the required documentation is available, the claim should be rebilled indicating the appropriate Pay Cycle numbers and Claim Reference Numbers of previous claim submissions for this service. Chapter I contains information on the billing limitation.	CO	Contractual Obligations	29	The time limit for filing has expired.	N29	Missing documentation/orders/notes/ summary/ report/chart. Note: Modified 8-1-05
0764	The date of service is more than 12 months old and the Department of Community Health is unable to verify previous activity. The documentation of prior activity is incomplete or differs from the original claim. If appropriate, the claim should be resubmitted with an explanation of the difference or with additional/corrected information.	CO	Contractual Obligations	29	The time limit for filing has expired.	N225	Incomplete/invalid documentation/orders/notes/summary/ report/chart. Note: Modified 8-1-05

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0765	The date of service is more than 12 months old.The Department of Community Health is unable to verify previous activity and the documentation of prior activity was not complete. If the required documentation is available, the claim should be rebilled indicating the appropriate Pay Cycle numbers and Claim Reference Numbers of previous claim submissions for this service. Chapter I contains information of the billing limitation.	CO	Contractual Obligations	29	The time limit for filing has expired.	N29	Missing documentation/orders/notes/ summary/ report/chart. Note: Modified 8-1-05
0766	A claim adjustment to request additional monies for a service can be billed up to 12 months from the date of the original payment. If there has been no active review (as explained in Chapter I), the claim must not be rebilled.	CO	Contractual Obligations	29	The time limit for filing has expired.	N152	Missing/incomplete/invalid replacement claim information. Note: New code 10-31-02
0767	If Medicare involvement prevented the claim from being billed to Medicaid within 12 months, refer to Chapter I for special billing instructions.	CO	Contractual Obligations	29	The time limit for filing has expired.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
0769	Drug code for the service billed is listed in the drug code listing.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Note: Modified 2-28-03
0771	The review of Medicaid records shows that this claim was previously paid. The claim must not be rebilled.	CO	Contractual Obligations	18	Duplicate claim/service.	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: Modified 6-30-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0772	Program records indicate that this beneficiary has, or is eligible for, Medicare. *****If the beneficiary is eligible for, but not enrolled in, Medicare, the provider should encourage the beneficiary to contact the local Social Security Administration office to reapply. For Inpatient Hospital Charges Only: The beneficiary is currently enrolled in Medicare Part B only. The provider should refer to Chapter IV of the Hospital Manual for instructions to initiate Medicare Part A coverage. The provider is reminded to keep Medicaid claims active according to the policies in Chapter I of the provider manuals.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0773	Medicaid reimbursement cannot be made for this service without further documentation from Medicare (e.g., Explanation of Benefits, voucher, written explanation). The provider should rebill the claim and include the appropriate documentation. LONG-TERM CARE PROVIDERS: The Explanation of Benefits is unacceptable documentation. HOME HEALTH AGENCIES: Medicaid reimbursement cannot be made for this service. Medicare will cover 100% of the cost or charge for home health services. There is no Part A or Part B deductible or coinsurance; therefore, the agency must not bill Medicaid for these services.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N29	Missing documentation/orders/notes/ summary/ report/chart. Note: Modified 8-1-05
0774	We have not received either an Informed Consent to Sterilization (MSA-1959) or Acknowledgment of Receipt of Hysterectomy Information (MSA-2218) form. Submit a completed form.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N28	Consent form requirements not fulfilled.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0775	The Informed Consent to Sterilization or Acknowledgment of Receipt of Hysterectomy Information form is invalid due to one or more of the following: Ø required information is missing, Ø information on the form does not match the claim, Ø the form is not appropriate for the procedure, or Ø the form is not accepted by the Program as a valid form (e.g., MSA-1959 or MSA-2218). This service cannot be billed to the beneficiary, his/her family or representative.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N228	Incomplete/invalid consent form. Note: New code 8-1-04
0776	The diagnosis code indicated does not match the diagnosis file. The provider should verify the diagnosis code used, correct, and rebill the claim.	CO	Contractual Obligations	**167**	**This (these) diagnosis (es) is (are) not covered. Change 4/06.**	M76	Missing/incomplete/invalid diagnosis or condition. Note: Modified 2-28-03
0777	Claim information is inconsistent with the submitted documentation or it is inconsistent with authorized services. All data should be verified.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N206	The supporting documentation does not match the claim. Note: New code 6-30-03
0778	Medical necessity for the services billed is not reflected by the diagnosis code. All data should be verified, including the diagnosis code subclassification digits, where indicated. If appropriate, corrections should be made and the claim rebilled. If the data is correct, the service must not be rebilled.	CO	Contractual Obligations	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	M76	Missing/incomplete/invalid diagnosis or condition. Note: Modified 2-28-03
0779	Unnecessary hospital days, or services contrary to Program requirements, are not reimbursable. This claim must not be rebilled until the provider has received the rebilling instructions.	CO	Contractual Obligations	152	Payment adjusted because the payer deems the information submitted does not support this length of service. Note: New as of 10-02	N185	Do not resubmit this claim/service. Note: New code 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0780	This beneficiary ID Number does not match the name and birthdate on the claim. The provider should verify the beneficiary ID Number with either the Medicaid ID Card/Eligibility Notice or the Eligibility Verification System. The claim should be corrected and rebilled.	CO	Contractual Obligations	140	Patient/Insured health identification number and name do not match. Note: New as of 6/99	MA36	Missing/incomplete/invalid patient name. Note: Modified 2-28-03
0781	The claim has been billed using the mother's beneficiary ID Number and the services are for a child. The provider should rebill the claim using the child's ID Number.	CO	Contractual Obligations	95	Benefits adjusted. Plan procedures not followed. Note: Changed as of 6/00	N15	Services for a newborn must be billed separately.
0782	This beneficiary does not have Medicare Part A, or Part A benefits are exhausted. The hospital charges for laboratory and/or radiology services must be included on a separate claim with other Part B charges. The provider should bill one claim showing all Part A charges, and a second claim showing all Part B charges, including the hospital laboratory and/or radiology charges.	CO	Contractual Obligations	119	Benefit maximum for this time period or occurrence has been reached. Note: Changed as of 2-04	M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
0783	The Department of Community Health's records indicate that the beneficiary's beneficiary-pay amount exceeds the total amount billed on this claim. The service must not be rebilled.	CO	Contractual Obligations	142	Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00	N185	Do not resubmit this claim/service. Note: New code 2-28-03
0784	Multiple procedures or services have been billed on separate claims. To be paid for this procedure or service, it is necessary to claim adjust the previously paid claim. A copy of the Remittance Advice page showing the paid claim must be sent with the claim adjustment.	CO	Contractual Obligations	B15	Payment adjusted because this procedure/service is not paid separately. Note: Changed as of 2/01	N152	Missing/incomplete/invalid replacement claim information. Note: New code 10-31-02
0785	Services billed exceed program limitations. The service must not be rebilled.	CO	Contractual Obligations	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Note: Changed as of 2/01	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0786	Claim information is inconsistent with authorized services. The service must not be rebilled.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N54	Claim information is inconsistent with pre-certified/authorized services.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0787	Claim information for the beneficiary does not agree with submitted documentation or does not agree with authorized services. All data should be verified. If appropriate, corrections should be made and the claim rebilled. If the data is correct, the service must not be rebilled.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N54	Claim information is inconsistent with pre-certified/authorized services.
0789	The other insurance code indicates payment made, yet there is no other insurance payment shown on the claim. The claim should be corrected and rebilled.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N245	Incomplete/invalid plan information for other insurance. Note: New code 8-1-04
0790	The required documentation regarding other insurance action is not complete. The provider should refer to Chapter IV of the appropriate provider manual. The claim should be corrected and rebilled.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N245	Incomplete/invalid plan information for other insurance. Note: New code 8-1-04
0792	The beneficiary is not eligible and there is no pending application on file. The service must not be rebilled.	CO	Contractual Obligations	31	Claim denied as patient cannot be identified as our insured.	N30	Patient ineligible for this service. Note: Modified 6-30-03
0793	The other insurance policy has master medical coverage. The service must be billed to the other insurance carrier.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0795	A manual review indicates these services are covered and benefits are currently available from another insurance carrier.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0796	This compounded prescription cannot be processed as the ingredients are not sufficiently identified by name, manufacturer, National Drug Code, strength, form, and quantity. The claim should be rebilled indicating complete documentation of the ingredients of the compound.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0797	There is an invalid relationship between the procedure code, diagnosis code, or drug code and the description of the services rendered. All data should be verified. If appropriate, corrections should be made and the claim rebilled. If the data is correct, the service must not be rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Note: Modified 2-28-03
0798	These services cannot be billed under the mother's ID Number. These services must be rebilled under the child's ID Number.	CO	Contractual Obligations	95	Benefits adjusted. Plan procedures not followed. Note: Changed as of 6/00	N15	Services for a newborn must be billed separately.
0799	(Adult Benefits Waiver Program only) This claim was not prior authorized and the diagnosis does not support emergency coverage.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care.	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0800	The payment is for the quantity shown. The explanation code is for informational purposes only.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N45	Payment based on authorized amount.
0802	Other insurance or Medicare money manually distributed. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0803	This provider type is not allowed for the beneficiary's age. The claim must not be rebilled.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Changed as of 10/98	N95	This provider type/provider specialty may not bill this service. Note: New code 7-31-01, Modified 2-28-03
0804	Services rendered to this county's Adult Benefits Waiver beneficiaries are the responsibility of the county. Providers should contact the Department of Human Services office for information regarding where to submit bills for these services.	CO	Contractual Obligations	96	Non-covered charge(s).	N30	Patient ineligible for this service. Note: Modified 6-30-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0805	Adult Benefits Waiver Program (ABW). Effective 11-01-1999 and after, payments for Adult Benefits Waiver (formerly State Medical Program) services will be made by the Detroit Medical Center (DMC). Providers should continue to submit claims for services to Adult Benefits Waiver Program beneficiaries to the Department of Community Health (DCH). DCH will continue to process the claims but payment will be issued by DMC. The explanation code is for informational purposes only.	CO	Contractual Obligations	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. Note: Changed as of 6/00	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0806	The procedure code is inconsistent with the modifier used or a required modifier is missing.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier. Note: Modified 2-28-03
0809	The service billed is part of the Mental Health or Substance Abuse Capitation and cannot be billed directly to DCH. These services should be billed to the Mental Health or Substance Abuse contractor in the beneficiary's catchment area.	CO	Contractual Obligations	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. Note: Changed as of 6/00	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0810	The National Drug Code (NDC) billed has been terminated by the manufacturer. If the wrong NDC has been billed, you should rebill using the correct NDC.	CO	Contractual Obligations	**181**	**Payment adjusted because this procedure code was invalid on the date of service. Change 4/06.**	M119	Missing/incomplete/invalid/deactivated/ withdrawn National Drug Code (NDC). Note: Modified 2-28-03, 4-1-04
0813	The quantity entry and package size for the National Drug Code (NDC) billed are inconsistent. The pharmacy should check the quantity entry on the claim to make sure that decimals were billed for fractional package sizes (e.g., 18.1 gms) or that the quantity relates to the NDC package (e.g., billing 21, not 28, for an oral contraceptive sold in packages of 21).	CO	Contractual Obligations	153	Payment adjusted because the payer deems the information submitted does not support this dosage. Note: New as of 10-02	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Note: Modified 2-28-03
0814	This National Drug Code (NDC) is being manually priced.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N45	Payment based on authorized amount.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0817	Outpatient hospital: Payment on this line is determined by group reimbursement policy. See section 7 of the Institutional Billing And Reimbursement chapter, procedure code/revenue code list. The explanation code is for informational purposes only. Revision 6-06	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0818	Medicaid Health Plan (MHP) psychotropic claim with invalid NABP number. Provider should verify correct NABP number and resubmit claim.	CO	Contractual Obligations	17	Payment adusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2-02	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Note: Modified 2-28-03
0819	Did not complete or enter accurately an appropriate HCPCS modifier.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier. Note: Modified 2-28-03
0821	The product cost is paid based on the lower of charge or the AWP minus 15.1% for pharmacies owning five or more stores, or for pharmacies with no retail customers serving long-term care beneficiaries. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charges exceed your contracted/legislated fee arrangement.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0822	The product cost is paid based on the lower of charge or the AWP minus 13.5% for pharmacies owning one to four stores. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charges exceed your contracted/legislated fee arrangement.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0823	The product cost is paid based on the lower of charge or manufacturer direct price. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charges exceed your contracted/legislated fee arrangement.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0824	The product cost is paid based on the lower of charge or a Maximum Allowable Cost (MAC) price. The Michigan Medicaid Drug List contains the MAC prices. Payment for a drug entity will not exceed the MAC price unless prior authorization is approved. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charges exceed your contracted/legislated fee arrangement.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0825	The claim was paid based on the lower of charge or estimated retail price or retail Maximum Allowable Cost (MAC) price. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charges exceed your contracted/legislated fee arrangement.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0827	Claim/service lacks a valid COB code which is needed for adjudication.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2-01	MA92	Missing plan information for other insurance. Note: Modified 2-1-04 Related to N245
0828	Our records indicate that there is insurance primary to ours; however, you either did not complete or enter accurately the group or policy number of the insured.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N245	Incomplete/invalid plan information for other insurance. Note: New code 8-1-04
0829	Secondary payment cannot be considered without the identity of, or payment information from, the primary payer. The information was either not reported or was illegible.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
0836	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	CO	Contractual Obligations	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0838	The disposition of this claim/service is pending further review.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N45	Payment based on authorized amount.
0839	The procedure code is inconsistent with the modifier used or a required modifier is missing.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier. Note: Modified 2-28-03
0840	The claim is reimbursed using the DRG policies. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0842	The services on this claim are reimbursed on a percent-of-charge basis.	CO	Contractual Obligations	45	Charges exceed your contracted/legislated fee arrangement.	N45	Payment based on authorized amount.
0843	The services on this claim, for this DRG, are reimbursed on a percent-of-charge basis. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0844	The claim indicates a low-cost outlier.	CO	Contractual Obligations	69	Day outlier amount.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0845	The alternative weight for the DRG reimbursement for this hospital was used in determining the reimbursement amount. The explanation code is for informational purposes only.	CO	Contractual Obligations	B22	This payment is adjused based on the diagnosis. Note: Changed as of 2/01	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0846	The inpatient hospital claim is for a transfer beneficiary and is paid the daily DRG rate. The explanation code is for informational purposes only.	CO	Contractual Obligations	87	Transfer amount.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0847	The claim indicates a low-day outlier.The claim is reimbursed at a percent-of-charge basis not to exceed the full DRG payment. The explanation code is for informational purposes only.	CO	Contractual Obligations	69	Day outlier amount.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0848	The claim indicates a high-day outlier. The explanation code is for informational purposes only.	CO	Contractual Obligations	70	Cost outlier - Adjustment to compensate for additonal costs. Note: Changed as of 6/01	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0849	The claim indicates a high-cost outlier. The explanation code is for informational purposes only.	CO	Contractual Obligations	70	Cost outlier - Adjustment to compensate for additonal costs. Note: Changed as of 6/01	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0850	The beneficiary was readmitted within 15 days of a previous discharge. Only the outlier payment is approved. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charges exceed your contracted/legislated fee arrangement.	N47	Claim conflicts with another inpatient stay.
0854	The Medicare coinsurance and deductible amounts for this DRG are being reviewed.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	MA63	Missing/incomplete/invalid principal diagnosis. Note: Modified 2-28-03
0855	The DRG assignment is being manually reviewed.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0856	This DRG requires prior authorization.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0857	This DRG is being manually reviewed to determine the medical necessity and/or appropriateness of the admission.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0858	Individual consideration has been requested for reasons other than transfer or readmission.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N45	Payment based on authorized amount.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0859	The wrong provider ID Number was used. Provider should correct the provider ID number and resubmit the claim.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New Code 12-2-04
0860	The claim does not contain sufficient information for a reimbursement determination.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N45	Payment based on authorized amount.
0861	The claim is reimbursed on a per diem basis. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N45	Payment based on authorized amount.
0862	Medicaid's internal group number for the hospital has caused the claim to pend.	CO	Contractual Obligations	45	Charges exceed your contracted/legislated fee arrangement.	N45	Payment based on authorized amount.
0863	The beneficiary was transferred to another facility/unit and the hospital has requested individual consideration for the full DRG payment.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N45	Payment based on authorized amount.
0864	Did not complete or enter accurately the CLIA number.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA120	Missing/incomplete/invalid CLIA certification number. Note: Modified 2-28-03
0865	The procedure code is inconsistent with the modifier used or a required modifier is missing.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier. Note: Modified 2-28-03
0866	Physician ER case rate: This claim line is for a service provided in the ER that is included in the ER case rate payment. This service has been paid zero dollars. The explanation code is for informational purposes only.	CO	Contractual Obligations	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded. Note: Changed as of 2/01	M85	Subjected to review of physician evaluation and management services.
0867	This claim was rejected because the beneficiary was admitted and discharged on the same day and no accommodation day was billed. The claim should not be rebilled unless there are both ancillary charges and accommodation day charges incurred.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M53	Missing/incomplete/invalid days or units of service Note: Modified 2-28-03

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0868	The beneficiary was admitted and discharged on the same day and an accommodation day was billed.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M53	Missing/incomplete/invalid days or units of service Note: Modified 2-28-03
0869	The Medicaid Health Plan rate cell could not be determined.	CO	Contractual Obligations	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid. Note: Changed as of 6/00	**N30**	**Patient ineligible for this service. Note: Modified 6-30-03; 4-6-04**
0874	The wrong Medicaid Health Plan ID number was used for the beneficiary's eligibility.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New Code 12-2-04
0875	Procedure code is not compatible with tooth number/letter. If appropriate, the claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N75	Missing/incomplete/invalid tooth surface information. Note: Modified 2-28-03
0876	A Medicare rate cell was used to pay the Medicaid Health Plan capitation rate for the beneficiary. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charges exceed your contracted/legislated fee arrangement.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0877	Pharmacy claims after July 2000 should be billed to First Health Services.	CO	Contractual Obligations	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N30	Patient ineligible for this service. Note: Modified 6-30-03
0878	The modifier reported is not allowed for the procedure code and no explanation was supplied.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier. Note: Modified 2-28-03
0879	The disposition of this claim/service is pending further review.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N225	Incomplete/invalid documentation/orders/notes/summary/ report/chart. Note: Modified 8-1-05
0880	The total amount billed on this claim is $0.00. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0881	This beneficiary has Medicare coverage and the claim indicates the beneficiary is not eligible for Medicare. The provider should verify that the correct COB indicator/status code was used, and rebill the claim.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N245	Incomplete/invalid plan information for other insurance. Note: New code 8-1-04
0882	This beneficiary has Medicare coverage and the claim indicates the beneficiary is not eligible for Medicare. The provider should verify that the correct COB indicator/status code was used, and rebill the claim.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N245	Incomplete/invalid plan information for other insurance. Note: New code 8-1-04
0883	The beneficiary is enrolled in a Medicaid Health Plan on the date of service but the hospital admission might be before the enrollment date.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N45	Payment based on authorized amount.
0884	The procedure code is inconsistent with the modifier used or a required modifier is missing.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier. Note: Modified 2-28-03
0886	For dates of service February 01, 2000 thru September 30, 2000, Health Plans are reimbursed directly by Medicaid only for psychotropic drugs dispensed to enrolled beneficiaries enrolled in the Health Plan. For dates of service October 01, 2000 and after, First Health Services is responsible for the Medicaid Health Plan psychotropic drug claims.	CO	Contractual Obligations	96	Non-covered charge(s).	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0887	The National Association of Board of Pharmacies Number (NABP #) is NOT on the Department of Community Health Provider Enrollment file.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New Code 12-2-04

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0888	The Department's payment to Health Plans for psychotropic drugs (other than anti-psychotic and side-effect drugs) is 60% of the lower of: The total Medicaid fee-for-service rate for product cost & dispensing fee, OR The Health Plan's contract pharmacy rate billed to the Department. NOTE: Anti-Psychotic and Side-Effect Drugs are paid at 100%, not 60%. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charges exceeded your contracted/legislated fee arrangement.	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0889	The occurrence code is missing. The explanation code is for informational purposes only.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M45	Missing/incomplete/invalid occurrence code(s). Note: Modified 12-2-04 Related to N299
0890	A modifier not appropriate for the procedure code has been reported and was not used to determine reimbursement.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N45	Payment based on authorized amount.
0891	This claim is reimbursed at the operating per diem plus capital costs per case. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0892	The wrong invoice document or electronic format was used.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N34	Incorrect claim form for this service.
0893	Maternity case rate was paid. The explanation code is for informational purposes only.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0894	Beneficiary not eligible for maternity case rate carve out.	CO	Contractual Obligations	**177**	**Payment denied because the patient has not met the required eligibility requirements. Change 4/06.**	N30	Patient ineligible for this service. Note: Modified 6-30-03
0895	This claim is reimbursed under the standard rate DRG methodology. The explanation code is for informational purposes only.	CO	Contractual Obligations	B22	This payment is adjused based on the diagnosis. Note: Changed as of 2/01	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0896	This claim is an additional page of a multi-page claim. No reimbursement is to be made. The explanation code is for informational purposes only.	CO	Contractual Obligations	97	Payment is included in the allowance for another service/procedure. Note: Changed as of 2/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0897	The claim is for Resident County Hospitalization services for a beneficiary not in Wayne County.	CO	Contractual Obligations	**177**	**Payment denied because the patient has not met the required eligibility requirements. Change 4/06.**	N30	Patient ineligible for this service. Note: Modified 6-30-03
0898	The claim is pending for determination of Medicaid reimbursement after Medicare's payment.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0899	The claim is pending for determination of Medicaid reimbursement.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0915	Services in the inpatient hospital setting are not benefits of the Adult Benefits Waiver Program. The claim must not be rebilled.	CO	Contractual Obligations	46	This (these) service(s) is (are) not covered.	N30	Patient ineligible for this service. Note: Modified 6-30-03
0929	The patient-pay amount has been subtracted from the amount approved. The explanation code is for informational purposes only.	PR	Patient Resposibility. Change 4/06.	142	Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00	N58	Missing/incomplete/invalid patient liability amount. Note: Modified 2-28-03
0930	This beneficiary is eligible for the Resident County Hospitalization Program as authorized by a county other than Wayne County. The hospital used the provider ID Number for the Wayne County PLUS CARE Program. The hospital must rebill using the correct provider ID Number.	CO	Contractual Obligations	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. Note: Changed as of 6/00	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New Code 12-2-04
0931	This beneficiary is eligible for the Resident County Hospitalization program as authorized by Wayne County. The hospital did not use the provider ID Number for the Wayne County PLUS CARE Program. The hospital must rebill using the correct provider ID Number.	CO	Contractual Obligations	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. Note: Changed as of 6/00	N14	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: New Code 12-2-04

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0932	The inpatient hospital claim indicates Source of Admission Form Locator 4 (Transfer from another hospital), or 6 (Transfer from another health care facility), and no admission authorization number is indicated on the claim. The explanation code is for informational purposes only.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0933	The physician's claim requires an authorization number for the admission. The explanation code is for informational purposes only.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0934	The date of admission is prior to the date of the admission authorization number.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N54	Claim information is inconsistent with pre-certified/authorized services.
0935	The admission date is more than 30 days after the date of the admission authorization number.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N54	Claim information is inconsistent with pre-certified/authorized services.
0936	The admission/readmission/transfer authorization number is missing.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0937	The admission/readmission/transfer authorization number is invalid.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0938	The admission/readmission/transfer authorization number on the claim was not assigned to this beneficiary.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N54	Claim information is inconsistent with pre-certified/authorized services.
0940	The admission date on the claim does not match the from date.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA40	Missing/incomplete/invalid admission date. Note: Modified 2-28-03

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0941	The hospice value code for the MSA number is missing or invalid. The claim should be rebilled with the appropriate MSA number.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M49	Missing/incomplete/invalid value code(s) or amount(s). Note: Modified 2-28-03
0942	The secondary surgical procedure requires an admission authorization number. The explanation code is for informational purposes only.	CO	Contractual Obligations	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0943	The secondary diagnosis requires an admission authorization number. The explanation code is for informational purposes only.	CO	Contractual Obligations	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0944	The primary surgical procedure requires an admission authorization number. The explanation code is for informational purposes only.	CO	Contractual Obligations	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0945	The primary diagnosis requires an admission authorization number. The explanation code is for informational purposes only.	CO	Contractual Obligations	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0946	The elective admission requires an admission authorization number. The explanation code is for informational purposes only.	CO	Contractual Obligations	62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Note: Changed as of 2/01	M62	Missing/incomplete/invalid treatment authorization code. Note: Modified 2-28-03
0947	A Patient Status Code of 30 (still a patient) was used on the inpatient hospital claim.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	MA43	Missing/incomplete/invalid patient status. Note: Modified 2-28-03
0948	The outpatient claim indicates emergency room services (Procedure Code 169032 or Revenue Code 450) and subsequent admission to the inpatient hospital setting.	CO	Contractual Obligations	B15	Payment adjusted because this procedure/service is not paid separately. Note: Changed as of 2/01	N20	Service not payable with other service rendered on the same date.

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0949	Professional charges are not allowed on an inpatient claim. Providers should refer to the billing chapter of the appropriate provider manual for instructions for billing professional services. The inpatient charges should be rebilled on the inpatient hospital invoice.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N34	Incorrect claim form for this service.
0950	This claim is being manually reviewed.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Note: Changed as of 10/99	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0952	Billing for more coinsurance days than claim line quantities.	CO	Contractual Obligations	152	Payment adjusted because the payer deems the information submitted does not support this length of service. Note: New as of 10-02	MA34	Missing/incomplete/invalid number of coinsurance days during the billing period. Note: Modified 2-28-03
0953	The office copayment has been deducted for the Adult Benefits Waiver Program beneficiaries. The explanation code is for informational purposes only.	CO	Contractual Obligations	3	Co-payment Amount	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0954	The adjustment reason code from the prior payer is being reviewed.	CO	Contractual Obligations	22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2-01	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0955	The National Drug Code is missing or invalid.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC). Note: Modifed 2-28-03, 4-1-04
0956	The product billed is not made by an allowable manufacturer. The product must not be rebilled.	CO	Contractual Obligations	96	Non-covered charge(s).	N180	This item or service does not meet the criteria for the category under which it was billed. Note: New code 2-28-03
0958	Medicaid cannot pay your claim based on the Claim Adjustment Reason Codes supplied by the prior payer.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Changed 4-06**	N36	Claim must meet primary payer's processing requirements before we can consider payment.
0959	The extended stay authorization number for a psychiatric or rehabilitation admission does not match the period being billed.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N54	Claim information is inconsistent with pre-certified/authorized services.
0960	The authorization number does not match this psychiatric stay.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N54	Claim information is inconsistent with pre-certified/authorized services.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0961	The number of days authorized does not match the number of days billed for this psychiatric stay.	CO	Contractual Obligations	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01	N54	Claim information is inconsistent with pre-certified/authorized services.
0966	Emergency ambulance invoice without emergency diagnosis code. The provider should enter the correct emergency diagnosis code from the ICD-9-CM code book in the diagnosis field of the claim form.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care.	M76	Missing/incomplete/invalid diagnosis or condition. Note: Modified 2-28-03
0967	Non-emergency ambulance code without referring provider ID Number. The provider should enter the ordering physician's name and Medicaid ID Number on the claim form and rebill.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N286	Missing/incomplete/invalid referring provider primary identifier. Note: New code 12-2-04
0969	Minimum quantity of 8 was not billed for continous home care. The provider should confirm the services being billed.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M53	Missing/incomplete/invalid days or units of service. Note: Modified 2-28-03
0970	Hospice services were billed for a beneficiary whose Level of Care is not 16. The Level of Care code should be verified and the claim rebilled as appropriate.	CO	Contractual Obligations	150	Payment adjusted because the payer deems the information submitted does not support this level of service. Note: New as of 10-02	N143	The patient was not in a hospice program during all or part of the service dates billed. Note: New code 10-31-02
0971	The supporting HCPCS code is invalid or missing. The claim should be rebilled with the appropriate HCPCS code.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	M20	Missing/incomplete/invalid HCPCS. Note: Modified 2-28-03
0972	Medicare pays 100% of this service. The service must not be rebilled.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 2-01; update 4-06**	N185	Do not resubmit this claim/service. Note: New code 2-28-03
0973	The provider has billed amounts (e.g., professional charges, Medicare charges, coinsurance/deductible) that are inconsistent for a Medicare coinsurance claim. The claim should be corrected and rebilled.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

August 2006 change in bold/orange
April/May 2006 changes bold/yellow prior changes in green

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0975	The provider has billed amounts (e.g., professional charges, Medicare charges, coinsurance/deductible) that are inconsistent for a Medicare coinsurance and deductible claim.	CO	Contractual Obligations	**45**	**Charges exceed your contracted/legislated fee arrangement: Changed 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
0979	Home health services were billed for a beneficiary who is in the nursing home, enrolled in a hospice program (Level of Care Code 16), or enrolled in Medicaid's Home & Community-Based Services Waiver for the Elderly & Disabled (Level of Care Code 22). The claim must not be rebilled.	CO	Contractual Obligations	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. Note: Changed as of 2/02	N79	Service billed is not compatible with patient location information.
0980	Medicaid reimbursement cannot be made for services rendered by this provider type. The service must notbe rebilled to Medicaid.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Changed as of 10/98	N95	This provider type/provider specialty may not bill this service. Note: New code 7-31-01, Modified 2-28-03
0981	Medicaid reimbursement cannot be made to this provider type for this service. The claim must not be rebilled to Medicaid.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Changed as of 10/98	N185	Do not resubmit this claim/service. Note: New code 2-28-03
0983	This procedure/service cannot be billed in combination with any other procedure/service billed on this date of service. The procedure/service must not be rebilled.	CO	Contractual Obligations	B15	Payment adjusted because this procedure/service is not paid separately. Note: Changed as of 2/01	N20	Service not payable with other service rendered on the same date.
0984	The procedure code requires documentation and documentation was not received with the claim. The claim should be rebilled with appropriate documentation attached.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriat. Note: Changed as of 2/02	N29	Missing documentation/orders/notes/ summary/report/chart. Note: Modified 8-1-05
0987	The Claim Adjustment Reason Codes supplied by the prior payer have been used to calculate the amount payable by Medicaid.	CO	Contractual Obligations	**23**	**Payment adjusted because charges have been paid by another payer. Note: Changed 2-01; update 4-06**	N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.